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Predicting escalation in sex offence recidivism:

Use of the SVR-20 and PCL: SV to predict outcome with non-contact recidivists and contact recidivists.

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Abstract

There is considerable responsibility on the clinician to identify sex offenders who may potentially commit more serious sexually violent behaviour and an increased demand for evidence based risk assessments (Macpherson, 1997; Thomas-Peter and Warren, 1998). Offenders who commit non-contact sexual crimes are traditionally classified as harmless despite the significant minority who escalate in offence severity towards more violent sexual offending.

Forty convicted male sex offenders were classified as non-contact or contact sexual recidivists. Non-contact recidivists had a history of non-contact sexual offending on two or more occasions. Contact recidivists had a history of non-contact offending and had recidivated with a contact sexual offence. Groups were compared on the Sexual Violence Risk–20 (SVR-20: Boer *et al.* 1997) and the Psychopathy Checklist: Screening Version (PCL: SV: Hart *et al.* 1995). Psychosexual variables, criminal history and clinical risk factors were also coded using a multi-variable assessment model.

A retrospective-prospective comparison successfully used by Quinsey *et al.* (1995) was performed between non-contact and contact recidivist groups. Factors that discriminated between non-contact recidivists and contact recidivists were primarily historical in nature, reflecting fixed or relatively stable characteristics. Significant differences between non-contact recidivists and contact recidivists were observed on total PCL: SV scores and psychosocial factors of the SVR-20 including sexual deviation, a history of childhood victimisation and past non-violent offences. Contact recidivists were significantly younger than non-contact recidivists at first non-sexual offence and were significantly more likely to have a history of homosexual offending. A high level of interrater reliability on the SVR-20 and PCL: SV was observed. Suggested revisions to several items of the SVR-20 and methodological considerations are reported.

The research demonstrates that a progressive pattern of sexual offending from non-contact sexual offending to contact sexual offending is reliably associated with a combination of risk factors. The study offers the potential for early detection of a more serious escalation in sexual offending to allow for the possibility of supervision and clinical risk management.

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Introduction

Sexual offending is witnessing a renewed concern amongst policy makers and an increase in public awareness. An accurate indication of rates of sex offending is notoriously difficult to estimate due to underreporting by victims of sex crimes. In a review of existing empirical studies on sex offender treatment in North America, Furby *et al.* (1989) found that sexual offending was a widespread problem. A more recent review of the literature found that true prevalence rates for sexual offending were difficult to estimate due to a low rate of reporting for sexual crimes (Furby, 1998).

In the UK, the British Crime Survey 1995 (Home Office, 1995) estimated a total of 30, 000 notifiable sexual offences recorded by the Police and a four-fold underestimate for most sexual offences. Criminal statistics for England and Wales show that 4600 men and 100 women were sentenced for

indictable sexual offences in 1995 (Home Office, 1995). In Scotland, sexual offending accounts for over 500 convictions per year, representing approximately one per cent of total crimes and offences (Scottish Office, 1996). Caution must be exercised when interpreting sex offender recidivism studies or number of convictions as they do not tell the researcher all about sexual offenders who commit crimes, but only those who are caught.

The estimates of victimisation rates provided by Russell and Howell (1983) indicate that there is at least a one-in-five chance that a female aged 16 years or older will be the victim of a rape at some time in her adult life. Peters, *et al.* (1996) and Koss (1993) reviewed prevalence rates of sex offending against children in North America and found that sexual assault is a serious social problem with victimisation rates amongst children of approximately 10 per cent of boys and 10-20 per cent of girls and women. Hanson *et al.* (1995) found that significant numbers of male community samples, including hospital staff and students, admit to sexual offending, with rates of between 10-25 per cent.

Taking prevalence rates and estimates of victimisation together, it is clear that sex offending is a serious problem that demands an effective solution. The meta-analysis of recidivism studies conducted by Hanson and Bussiere (1998) and comprehensive reviews of the treatment literature by Furby *et al.* (1989) indicate that sexual offending is relatively intractable. Hanson *et al.*

(1993) found scant evidence to date that sexual offending can be significantly or effectively reduced by psychological or pharmacological treatment.

Risk assessment

If sex offender treatment as it stands cannot appreciably reduce recidivism rates then there is a need to forecast which individuals are at greatest risk of offending again, against whom, and with what severity. Hanson and Harris (1998) stated that economic, ethical, humanitarian and practical concerns rule out the possibility of indefinite detention for all sex offenders. Consequently there has been an increasing demand in the literature for psychologists to provide objective, evidence based assessments of sexual offenders to guide clinical practice and decision making (Macpherson, 1997; Thomas-Peter and Warren, 1998).

The attempt to understand and manage risk is the process known as 'risk assessment' and there has been a strong and growing interest in this area over the past two decades (Monahan and Steadman, 1994). Risk assessment has become a feature in many seemingly disparate fields including medicine, business, and weather forecasting.

In general terms, risk is a hazard whose occurrence can only be forecasted with uncertainty. Within forensic psychology, Menzies *et al.* (1995) define

risk assessment as a process of identifying and studying hazards to reduce the probability of their occurrence. Boer *et al.* (1997a) define the concept of risk as multifaceted and refer to risk as (1) the nature of the hazard (2) the likelihood that the hazard will occur, (3) the frequency with which the hazard will occur, (4) the seriousness of the hazard's consequences, and (5) the imminence of the hazard's occurrence.

The increased demand for evidence based risk assessments has posed a number of obstacles to the clinician responsible for decisions regarding risk assessment and management. Clinical experience suggests that assessment of sexual offenders within the UK criminal justice system is poorly defined and lacks an evidence base on which to conduct assessments of risk of recidivism, despite an increasing requirement for such assessments (Macpherson, 1997). As Rice and Harris (1997) note:

"When a released offender commits a particularly violent or repugnant offence, there is often a public outcry that decision makers ought to have foreseen the event and prevented the release. When decision making becomes too conservative, institutions become overcrowded and expensive to operate. In addition, offenders who are unlikely to re-offend are forced to spend longer periods of time incarcerated than necessary for the protection of the public"

p 231.

Accurate and comprehensive risk assessment for sexual offenders remains a current and important issue for the criminal justice system in general, and psychologists in particular.

Professional judgement

Historically, the most common-used approach to risk assessment has been unstructured clinical or 'professional' judgement. The hallmark of this approach is that no constraints are placed on how evaluators reach decisions based on the information available to them (Meehl, 1954). The 'informal, subjective and impressionistic' approach offered by unstructured clinical judgement has been criticised on a number of grounds (Grove and Meehl, 1996) and there are inherent difficulties with this method of risk assessment. As Boer *et al.* (1997b) note, there tends to be a low inter-rater reliability and lack of consistency or agreement across evaluators with respect to how evaluations are conducted or how decisions are reached. Second, Monahan and Steadman (1994) reported on the paucity of evidence that decisions made using professional judgement are accurate due to the low reliability and failure to demonstrate that decisions improve significantly over chance. Third, clinicians may fail to specify how they reached a decision. This makes it difficult for professionals engaged in the process of risk assessment to determine the reason for disagreement.

There is a valid and widely held opinion within the UK that professional judgement has the advantage of flexibility. Grubin (1997) has argued that a more clinical approach to assessment is required to estimate risk of sexual offending in particular. The research of Hanson and Harris (1998) on predictors of sexual recidivism stressed the importance of dynamic or changeable factors in addition to static and highly stable predictors.

Mossman (1994) reanalysed 44 published studies from the past two decades on the prediction of violence in general and produced results supportive of the predictive accuracy of clinical judgement over the short and long term. Mossman contends that knowledge of past behaviour may outperform professional judgement relying on clinical interview alone - an illustration of the importance of both 'behavioural consistency', and the use of collateral information in the decision making process. Mossman's study was important in influencing the move away from actuarial or statistical approaches to risk assessment alone, and the move towards the development of guidelines informed by clinical opinion.

Actuarial or statistical prediction

Reviews of the North American literature on risk assessment by Monahan and Steadman (1994) and Webster *et al.* (1994) are consistent in the opinion that unaided clinical judgement improves only marginally over chance in the prediction of recidivism although Mossman (1994) found that clinical

judgement outperformed actuarial prediction over the longer term. There has been an increased emphasis on risk assessment for offender recidivism within the UK to incorporate actuarial approaches when estimating recidivism. One major area of investigation has been the development of statistical risk scales to improve the accuracy of predictions of re-offending.

Cooke and Michie (1997) used a six-variable actuarial model to predict general recidivism of a young offender prison population within two years of release from custody. They achieved a 'hit' rate of 83 per cent accuracy within two years of release to confirm the importance of simple, readily accessible actuarial variables in determining risk of recidivism.

Monahan (1995) has suggested that actuarial approaches to risk assessment are superior to unstructured clinical judgement with respect to decision-making and a structured empirical approach can improve the consistency and accuracy of risk assessment when predicting general criminality and violent recidivism.

Sex offence recidivism and risk assessment

Meta-anaylsis and reviews of recidivism studies conducted in North America by Hanson *et al.* (1995), Hanson and Harris (1998) and Hanson and Bussiere, (1998) have found that sexual offending is a distinct type of crime with its own set of risk factors. There are at present several actuarial

scales to predict risk for sexual offending. Quinsey *et al.* (1995), in a retrospective analysis of incarcerated offenders, identified 13 variables associated with recidivism. These included a phallometric index of sexual deviation and a standard measure of personality disorder. They were able to identify recidivist sexual offenders with 77 per cent accuracy. However, further analysis on the predictive properties of the scale with sex offenders led the authors to recommend abandoning it in favour of an actuarial scale for general violence (Rice and Harris, 1997).

Hanson and Bussiere (1998) conducted a meta-analysis on the predictors of sexual offence recidivism using the data of 61 follow up studies conducted between 1943 to 1995 involving 28,972 Canadian offenders. They established three types of predictor variables: criminal lifestyle, sexual deviance, and psychological maladjustment. They assessed the predictive accuracy of the variables with respect to general recidivism, non-sexual violent recidivism, and sexual recidivism. Results indicated that sexual recidivism was best predicted using measures of sexual deviancy. The authors recommended against using the results in an actuarial manner and suggested that the factors would prove of most utility as clinical guidelines.

Two further promising approaches have been the Sex Offender Risk Appraisal Guide or SORAG (Quinsey *et al.* 1995) and the Rapid Risk Assessment for Sexual Offence Recidivism or RRASOR (Hanson 1997).

The SORAG was developed on the basis of retrospective studies of rapists and child molesters assessed at the Penetanguishene maximum-security forensic hospital in Ontario, Canada. Quinsey *et al.* (1995) identified a set of socio-demographic, criminal history, and clinical variables that discriminated between recidivists and non-recidivists in a sample of 178 sex offenders. The SORAG was also found to discriminate between those who breached conditions of release and those who did not breach conditions on release from custody. However, more recent research on the SORAG indicated that the scale performed poorly on cross-validation and it was subsequently revised (Rice and Harris, 1997).

The RRASOR was developed by Hanson's (1997) extension of the meta-analysis conducted by Hanson and Bussiere (1998) who identified a small set of socio-demographic and criminal history variables that differentiated across studies with minimal redundancy between recidivist and non-recidivist sex offenders. Despite these promising attempts at developing an actuarial instrument for predicting sex offence recidivism, there is no evidence to date that either the SORAG or the RRASOR have predictive validity with respect to sexual violence. Hanson and Harris (1998) found no significant differences on the RRASOR in a retrospective file review comparison between 208 recidivist and 201 non-recidivist sexual offenders. There has been no published research that has administered the SORAG or

the RRASOR to sex offenders on release from an institution to determine the accuracy of predictions of sexual violence at follow-up.

Actuarial assessment is one method for predicting general recidivism although there are difficulties for the clinician using actuarial assessment alone to forecast risk of re-offending with sex offenders. First, the available actuarial scales consider only a small number of risk factors. This may ignore factors that may be important but idiosyncratic to particular sex offences. Munro and Macpherson (1998) developed a clinical construct interview schedule for use with prison populations to accurately gather information pertinent to risk assessment. They suggested that assessment of offenders requires to be flexible and comprehensive with multiple sources of information where possible.

Second, actuarial scales focus attention on static or stable demographic features or criminal history variables. As a result, predictions of risk made using actuarial instruments may be of limited practical use. As Boer *et al.* (1997b) note:

"How is one to intervene if an individual is at risk because he is male? How can one assess changes in risk over time if the decision is based primarily on past convictions?" p. 4

Third, due to their primary emphasis on empiricism, actuarial assessments may include risk factors that are unacceptable on legal grounds or are entirely logical but of unknown validity (Hart 1998). For example, the actuarial method of violence prediction used by the Violence Risk Appraisal Guide (Rice and Harris, 1995) provides a lower estimate of risk of recidivism if an offender has committed a murder against a female than if the offender had simply threatened a male. Fourth, sex offending is not a unitary phenomenon. An actuarially derived score indicating high risk does not discriminate between an offender who might be at high risk of further offences of exhibitionism or an offender who might rape a male child victim.

There have been more general criticisms of actuarial assessment in general. It is argued that risk assessment based on a statistical model disengages professionals from the evaluation process. Actuarial scales may involve minimal professional judgement and, as such, professionals may tend to over estimate or under utilise actuarial data when making a risk prediction.

Furby (1998) criticised the meta-analysis conducted by Hanson and Bussiere, and by implication, the RRASOR, which was developed largely on the results of the analysis. The main criticism was on methodological grounds as most of the 61 studies contained in the meta-analysis used

inadequate methods for calculating recidivism rates and relied on diverse methods to obtain follow-up data.

Similar reviews by Furby, Weinrott and Blackshaw (1989), observed that averaging recidivism rates across studies whose follow up rates vary (in the case of Hanson and Bussiere, from 6 months to 23 years) may not produce meaningful results. Bonta and Hanson (1994) have also indicated that many sex offences remain undetected. As Boer *et al.* (1997b) conclude, there are at present no well-validated actuarial scales to assess risk for sexual violence.

Physiological assessment measures

Physiological measures, or phallometric assessments, have been reported in the literature as indicators of deviant sexual interest in a number of reviews and treatment studies (Barker and Howell, 1992; Simon and Shoulten, 1993). Phallometric (PPG) procedures typically measure penile tumescence in response to stimuli (slides or audiotapes containing explicit sexual content). Phallometrically determined sexual deviance has been reported as a valid indicator of deviance and used as a predictor of sexual recidivism by several researchers (Quinsey *et al.* 1995; Rice and Harris, 1997) although the literature is not entirely in agreement on the predictive usefulness of phallometric assessment.

There remain a number of weaknesses with a physiological approach to the assessment of sexual deviation and the estimation of recidivism rates from this type of assessment. First, Barker and Howell (1992) found that phallometric indices of deviant sexual arousal or procedures in general were not standardised. Second, Wilson (1998) examined a group of male university students instructed to 'fake' the result of a phallometric test, and indicated that phallometric testing was easily falsified. Simon and Shoulten (1993) suggested that problems with standardisation and faking warrant much more guarded conclusions of the assessment of deviance using a phallometric approach, particularly in clinical and legal settings.

Howes (1995) is more vocal in his criticism of phallometrically determined deviance. He surveyed 48 of the 153 centres in North America currently using phallometric assessment methods and found abundant inconsistency in both plethysmographic assessment procedures and interpretation of data.

In the UK there have been calls for standardised stimulus material and more reliability data as well as the development of procedures to discourage faking (Gilles, 1997).

A further issue concerns the ability of phallometric assessments to discriminate between discrete groups of sexual offenders. The ability of penile plethysmography to discriminate between extra-familial child

molesters and non-sex offenders appears to be established. However, incest sexual offenders commonly exhibit normal age sexual preferences during phallometric assessment when compared to extra-familial child molesters matched on age, and victim-age and gender (Quinsey *et al.* 1979). The meta-analysis of Hanson and Bussiere (1998) found that phallometric assessment of sexual interest in rape was not related to recidivism. It has been suggested that phallometric assessment may relate only to sex offenders against children. However, Barbaree and Marshall (1989) found that normal subjects become aroused in response to paedophilic stimuli, while Hall *et al.* (1988) observed that non-paedophilic sex offenders become aroused to paedophilic stimuli. Hall, (1990) suggested that the deviant patterns in non-offenders, and the non-deviant patterns in sex offenders towards deviant stimuli, may result in an unacceptably high number of false positives.

Taken in summary, doubts exist over the validity and reliability of current physiological methods. Hall (1990) observed that there is an overemphasis on physiological measures given the problems with external validity of penile measures of sexual arousal. This represents an obvious limitation for predictions of future risk based on phallometric assessment. There are also general concerns with respect to the safety of the general public and for the rights of the patient if phallometric methods prove unreliable. Second, there are moral and legal problems associated with employing this type of

procedure with patients within the UK due to the explicit nature of the stimulus material. In addition, the cost of providing a laboratory specifically designed to conduct phallometric assessments is substantial.

In a review of the literature, Blackburn (1993) commented that there remain a number of theoretical and technical issues to be resolved before the validity and clinical utility of the PPG assessment can be considered as firmly established.

Technically less-complex measures such as viewing time have recently been reported in the literature. This method involves the use of slides depicting various age and sex groups. A measure of time spent viewing each slide is recorded to provide an estimate of sexual interest in the particular material. Recent research has suggested that this simple and less intrusive procedure yields comparable result in comparison to existing phallometric procedures. The work of Abel and others (Abel *et al.* 1998) at the Behavioural Medicine Institute of Atlanta found that visual reaction time (Visual RT) has a high validity and reliability for assessing sexual deviance. Abel *et al.* (1998) have suggested that Visual RT has the added advantage that it can be used without explicit sexual material and is a more cost-effective assessment in comparison to existing phallometric assessment procedures.

However, the preliminary research on Visual RT did not contain a control group and the participants per category for plethysmographic studies were smaller than for the Visual RT group. There is also some doubt as to the validity of the results when the problems with external validity of the existing penile measures of sexual arousal as used in the study are taken into consideration. Visual reaction time is a new assessment method and requires further research to ensure that the problems associated with existing plethysmographic measures are not repeated.

Physiological measures have not been widely adopted in the UK. Some observers have suggested that they should be regarded as experimental in nature rather than absolute indicators of sexual deviance (Hall, 1990). In the absence of a specialist laboratory based assessment procedure, the general wisdom has been to rely on more traditional methods of assessment.

Structured clinical judgement

In the absence of a well-validated actuarial scale for predicting risk of sexual violence or unanimous agreement between clinicians on physiological assessment methods, some authors have suggested adopting 'structured clinical judgement', that is, risk assessments conducted according to explicit guidelines that are grounded in the scientific literature (Boer *et al.* 1997a). It has been suggested that statistical and clinical

composites may be superior to either actuarial or clinical methods alone in predicting recidivism with sex offenders (Holland *et al.* 1983) and the analysis of two decades of violence prediction studies conducted by Mossman (1994) produced reasons to be confident in the accuracy of clinical judgement over actuarial assessment over the longer term.

Structured clinical guidelines can improve unaided clinical judgement by making risk assessments more systematic and open to evaluation. Munro and Macpherson (1998) found that dynamic factors are of interest to the clinician as they can be the focus of supervision and treatment, and involve issues about which, in principle, something can be done to modify level of risk. Hanson and Bussiere (1998) have also suggested that guidelines informed by the empirical research can improve the accuracy of violence predictions.

There is an increasing demand placed on the clinician to justify an assessment and to ensure competency, adequacy, and defensibility of risk assessment procedures. There exists the possibility of *Tarasoff* (1976) liability or 'duty to warn' and the obligation placed on psychologists to exercise reasonable care being applied to risk assessments in the UK. With this concern in mind, structured clinical judgement appears to have reasonable face validity as a legally defensible method of assessment.

The Sexual Violence Risk-20 (SVR-20: Boer *et al.* 1997a)

Boer *et al.* (1997a) provide a set of guidelines for the structured clinical assessment of risk of sexual offending. They refer to these guidelines as the Sexual Violence Risk-20 (SVR-20). The SVR-20 is a practical guide which considers clinical and empirical factors reported in the literature known to be associated with recidivist sexual violence in sex offenders. The authors define sexual violence using intentionally broad terms to incorporates the nature of the act, and the victim of the sexual offence:

"actual, attempted, or threatened sexual contact with a person who is non-consenting or unable to give consent" p9 Boer *et al.* (1997a).

The SVR-20 consists of twenty risk factors divided into three major sections. The sections and risk factors have been defined according to conventional clinical opinion. As such they are not statistically computed factors and the individual items are not equally weighted. The items are intended to be elicited by semi-structured clinical interview and file review.

The first section relates to psychosocial adjustment, and considers factors that are historical in nature, reflecting either fixed or relatively stable characteristics, past and current functioning, and general social and anti-social behaviour. The second section involves historical and dynamic

factors relating to sex offence behaviours. The third section reflects future plans. A general rule is that the greater number of individual risk factors that an individual meets on the SVR-20, the greater the level of risk.

SVR -20 - Definition of risk factors

Boer *et al.* (1997a) suggest that the SVR-20 summarises contemporary empirical research studies and current professional opinion concerning the definition of risk factors. The SVR-20 is a relatively new scale and fulfils the criteria for a 'forensic assessment instrument' (Grisso, 1986) although the properties and predictive ability of the scale have yet to be fully established. The following is a rationale for the inclusion of each risk factor in the SVR-20. The following review is based on the brief description of items contained within the manual and a comprehensive review of the clinical literature and research studies on sex offending to support or challenge the inclusion of each item.

A. Psychosocial adjustment

1. Sexual Deviation.

Blackburn (1993) has commented that sexual deviation depends on societal standards and the fluctuating boundaries between normal and abnormal sexual behaviour. It is clear that some sexual interests are psychologically damaging for the individual as well as socially dysfunctional, and these are generally referred to as sexual deviations.

Sexual deviation is also known as deviant sexual preference or paraphilia, and involves a stable pattern of sexual arousal to inappropriate people or objects, and causes distress or social dysfunction. The established criteria for a number of sexual deviations are contained within conventional and widely used diagnostic manuals such as the DSM-IV (APA, 1994).

The meta-analysis conducted by Hanson and Bussiere (1998) established sexual deviation based on the diversity of sexual acts committed as well as direct reports of deviant sexual interests or activities. Reports of phallometric assessment were available in 30 per cent of their sample. They found that the presence of a stable pattern of abnormal or dysfunctional sexual arousal was a significant factor with regard to recidivism. Quinsey *et al.* (1995) studied 54 sexual offenders and found that sexual recidivists had more phallometrically determined sexual interest in non-sexual violence against women. Rice and Harris (1997) used phallometric assessment to determine deviance and found that sexual violence motivated primarily by sexual deviation increased the risk of re-offending. They concluded that sexual deviation was a significant predictor of recidivism. Langstrom (1999) found that sexual deviance predicted sexual re-offending amongst a group of 56 young sex offenders. Boer *et al.* (1997b) indicate that offending motivated by sexual deviation is a risk factor for recidivism whether the deviation is inferred from the offender's history of sexual behaviour or

through plethysmographic assessment of sexual arousal. Hanson and Harris (1998) found that recidivist sexual offenders were judged to be more sexually deviant than non-recidivists. Taken in summary, there is a strong and consistent opinion in the literature that sexual deviation is a primary factor to consider when assessing risk with sex offenders.

2. Victim of child abuse.

Reviews of the literature suggest that a history of child abuse may be linked to sex offending, possibly because of the influence of childhood sexual abuse on the development of deviant sexual practices (Marshall *et al.* 1990). Hanson and Harris (1998) found that recidivist sexual offenders were more likely to have histories of sexual and emotional abuse, with 27 per cent of recidivists having been taken into the care of child protective services compared to 15 per cent of the non-recidivists.

In a review of the literature, Jehu (1991) concluded that there was an association between sexual offending in adulthood and a history of sexual abuse in childhood. Jehu (1991) has suggested that sexually abused males may be more prone to engage in violent behaviour including sexual violence in later life.

Not all studies have produced consistent findings regarding the role of sexual abuse as a risk factor for sexual offending. Hanson and Bussiere

(1998) found that a history of sexual abuse as a child was not associated with an increased risk of sexual recidivism. In a primarily descriptive study, Sugarman *et al.* (1994) failed to find an association between more serious sexual recidivism and a history of abuse or neglect, although there may have been difficulties extracting sufficient data from case notes spanning almost three decades. There is also some debate as to the link between child abuse and sex offending. Socio-psychological theories suggest that child abuse is a causal factor (Marshall *et al.* 1990) while bio-psychological theories view an abuse history as a risk marker (Boer *et al.* 1997b).

3. Psychopathy.

Psychopathic personality disorder as assessed using the Psychopathy Checklist-Revised (Hare, 1991) is considered a risk factor for predictions of general and violent recidivism (Hart and Hare, 1997). Rice and Harris, (1997) found a strong relationship between scores on the PCL-R and sexually violent recidivism. A similar finding was made by Rice *et al.* (1990), particularly when the PCL-R was combined with measures of sexual deviance. Quinsey *et al.* (1995) found that 77 per cent of a group of 54 rapists could be correctly classified as non-recidivists and sexual recidivists based on a combination of PCL-R ratings and a phallometric assessment of sexual deviance. This finding was not replicated in a recent study of recidivism rates with 86 convicted rapists (Firestone, *et al.* 1998).

Follow up studies of sex offenders indicate that psychopathy is predictive of general criminality (Hart and Hare, 1997), non-sexual violence (Hart and Hare, 1997; Harris *et al.* 1993), and a moderate predictor of sexual violence (Quinsey *et al.* 1995). Psychopathy is currently considered to be an untreatable condition and this has an obvious link to decisions regarding the management of potential for future sex offending (Rice, *et al.* 1990).

The research of Cooke and colleagues (Cooke, 1995; Cooke, 1998; Cooke *et al.* 1999; Cooke and Michie, 1997) on the cross-cultural validity of the PCL-R for use within the UK, and the reliability of the PCL: SV, is further explored below. Given the importance of this item, and the use of a screening version of the Hare PCL-R in the current research, a more full description of psychopathy's relationship to general, violent, and sexual offending is described below.

4. Major mental illness.

Boer *et al.* (1997b) have considered a number of factors as representing major mental illness including serious cognitive or intellectual impairment (dementia, learning difficulty); psychotic disorders (e.g. schizophrenia, delusional disorders); and mood disorders (e.g. major depression, bipolar mood disorder) where diagnoses are made according to standardised criteria (e.g. DSM-IV, APA, 1994).

Mental disorder, in particular psychotic disorders or intellectual deficits, is considered in professional reviews to be a risk factor for sexual violence due to the potential of these conditions to seriously impair an individuals judgement or emotions. Douglas and Hart (1996) found a strong relationship between psychosis, mania, and violence in a meta-analysis concerning the relationship between mental disorder and violent behaviour. Hodgins (1992) found that men with major mental disorder were 2½ times more likely than men with no disorder to be registered for a criminal offence and four times more likely to be registered for a violent offence. The relationship for mental disorder and crime for females was significantly higher.

Hodgins (1992) found learning difficulty/mental handicap to be a risk factor for offending in a longitudinal prospective study of over fifteen thousand unselected birth cohorts in Sweden. The author found that men classified as learning disabled were three times more likely to commit a general offence and five times more likely to commit a violent offence than men without a diagnosis of learning difficulty or disorder. The relationship between learning disability and sex offending was not examined. A formal diagnosis of mental handicap was not made on the basis of standard psychometric testing but on a history of special schooling. The author observed that there may be a marked cross-cultural difference between the Swedish sample and a North American comparison of offenders, due to a significantly higher

rate of crime in general, and high levels of crime by North America substance abusers in particular.

Bradford (1994) reviewed a number of case studies of sexually deviant men and found learning difficulty to be strongly associated with sex offending. Noteworthy is the finding of Hawk *et al.* (1993) who found a prevalence rate of over eight per cent of learning disabled sexual offenders in a sample of 2500. The rate of sexual offence charges was nearly twice as high among offenders with a learning difficulty compared with other offenders. Murray *et al.* (1992) reviewed the records of 106 personality disordered, mentally ill, and mentally handicapped sex offenders, and found that paedophilic behaviour was found most commonly in the mentally handicapped group and was almost non-existent in the mentally ill group. Low intelligence emerged as a feature of sexual offenders convicted of a contact offence in the study of Sugarman *et al.* (1994).

5. Substance abuse problems.

The early studies of Rada (1978) and Amir (1971) based on offenders accounts of the index offence, found that between 50 to 60 per cent of convicted rapists had been drinking at the time of the crime. Rada (1978) also observed that one third of his sample of rapists admitted to alcohol dependence. The laboratory studies of George and Marlatt (1986) with a male student population found that alcohol expectancy increased sexual

arousal to erotic films and erotic violence.

Hodgins' (1990) review of violence rates found that substance abuse problems, including the misuse of alcohol or illicit and non-prescribed drugs, are associated with an increased risk for general violence. The review of risk factors for sexual offending by McGovern and Peters (1988) found that problem drug or alcohol use may also lead to an increased likelihood of behavioural disinhibition resulting in an increased propensity towards sexual offending. This finding is supported in the clinical research of Quinsey *et al.* (1995). Boer *et al.* (1997b) reported that some offenders may use substances to disinhibit themselves when they are considering sexual violence. Overholser and Beck (1989) attempted to differentiate a group of rapists and a group of sex offenders against children on the basis of social skills and attitudes towards sex and violence. They highlighted the significant role that alcohol played in impairing the offender's ability to voluntarily suppress sexual arousal. The meta-analysis of Hanson and Bussiere (1998) found substance abuse problems predicted general criminality and increased risk for violence in general with sex offenders.

In a descriptive study of 20 mentally ill sex offenders admitted to a regional secure unit over a twelve-year period, Chesterman and Sahota (1998) found that 60 per cent of their sample reported alcohol and substance abuse at the time of the index offence. Forty per cent admitted to the abuse of alcohol

and twenty per cent admitted to the abuse of substances. No comparison between mentally ill offenders and non-mentally ill offenders was made. Sugarman *et al.* (1994) found that a history of alcohol or other substance abuse was not associated with contact sexual offending. However, the authors suggested that the discrepant finding may have resulted from the difficulty in gaining accurate and detailed information from case files reviewed with a follow-up period of eight to 25 years. Taken in summary, there is considerable evidence that alcohol is a significant factor to consider when assessing risk of recidivism with sex offenders.

6. Suicidal ideation or stated intention to harm others.

There is little empirical evidence to support this item's inclusion as a risk factor for sexual offending. This may reflect the fact that individuals presenting in this manner may be involuntarily detained or sectioned for treatment and this prevents the opportunity of offending. The author has worked with several cases where offenders expressed suicidal and homicidal intent, or a stated intention to commit acts of sexual violence, prior to the commission of a serious sexual offence. In these cases, such ideation signalled the presence of a serious sexual deviation, in particular, sexual sadism.

Boer *et al.* (1997b) reported that suicidal ideation or stated intention to harm others should be considered risk factors for sexual recidivism. Kropp *et al.*

(1995) reviewed the risk factors relating to domestic abuse and found that homicidal ideation was associated with a risk of spousal assault in the literature relating to domestic violence. Hart (1999) stated that although there is no scientific evidence to demonstrate the relationship between suicidal or homicidal intent to sexual violence risk prediction, it would be wrong to omit this item from any scheme predicting risk of harm to self or others.

7. Relationship problems

Andrews and Bonta's (1994) review of the literature on offenders in prison and forensic out-patients found offenders with unstable intimate relationships tended to have more extensive criminal histories, a higher frequency of violent offences, and a higher rate of general violent recidivism than those with stable relationships. A failure to establish or maintain stable, long-term intimate relations, and poor relations with family of origin, are factors associated with sexual recidivism in the meta-analysis conducted by Hanson (1997) and Hanson and Bussiere (1998). Hanson and Harris (1998) found the early family background of recidivist sexual offenders to be significantly worse than that of non-recidivists. In a small-scale study within the UK, Grubin (1994) found that a lack of heterosexual relationships was the most notable characteristic in 21 male sexual murderers as compared to 121 rapists. It has been suggested that a history of poor relationships might be associated with a personality disorder that

prevents the offender managing to achieve legal sexual contacts (Boer *et al.* 1997b).

8. Employment problems

A failure to achieve and maintain stable employment is a risk factor with regard to general violence and sexual offending (Andrews, 1991; Andrews and Bonta, 1994; Monahan, 1995). It has been a long-established opinion that unemployed offenders are more likely to recidivate violently (Tittle *et al.* 1978). In a review of factors associated with domestic violence, Campbell (1986) found low income and financial stress to be risk factors for spousal assault.

Employment problems may be a risk marker for sexual violence because of the possible association with personality disorder or severe sexual deviance and difficulty establishing or sustaining long-term employment (Boer *et al.* 1997b). Clinical reviews have suggested that employment problems can lead to short term distress which sometimes lead to short term increases in sexually deviant thoughts and urges (Proulx *et al.* 1997). Taken in summary, there is strong agreement in the literature on the relationship between employment problems and violence. The relationship between employment and sexual offending appears to be more modest.

9. Previous history of non-sexual violent offending

A previous history of non-sexual violent offending is a risk factor for criminality and violence among criminal offenders and forensic patients (Harris *et al.* 1993; Monahan, 1995). The meta-analysis of Hanson and Bussiere (1998) and clinical review of Ross and Loss (1992) found that non-sexual violent criminality was associated with sex offending. Boer *et al.* (1997b) state that the presence of a personality disorder, in particular anti-social personality disorder, or the presence of anti-social attitudes that underlie criminal offending, predict recidivism due to the pro-criminal sentiments that encourage 'lifestyle criminality'.

In the UK, Chesterman and Sahota (1998) found that 75 per cent of mentally ill sex offenders admitted to a regional secure unit had a previous non-sexual violent conviction preceding first contact with psychiatric services. In addition, the principle of 'behavioural consistency' suggests that the best predictor of re-offending is past offending, and that the risk increases with every new offence.

10. History of general, non-violent offending

Monahan's (1995) authoritative review of the literature on violence prediction established a history of general, non-violent offending, as a risk factor for violence and sexual violence amongst forensic patients. The meta-analysis of Hanson and Bussiere (1998) using 61 follow up studies

conducted between 1943 to 1995 involving over 28 thousand offenders established a relationship between a history of non-violent offending and future risk of sexual recidivism. McGovern and Peters (1988) also considered a history of non-violent offending to be an important factor to consider when conducting risk assessments. In the UK, Sugarman *et al.* (1994) found an association between acquisitive offending and escalation towards more serious sexual offending amongst a group of 210 genital exposers over a follow-up period ranging between 8 and 25 years.

11. Violation of the conditions of release or community supervision.

In a study to determine the recidivism rates of prisoners released from a Canadian federal prison, Bonta *et al.* (1996) found that individuals who had violated the conditions of release or community supervision were at increased risk for criminality and violence. The research of Rice and Harris (1997) on sex offender recidivism within North America found evidence to support supervision failure as a risk factor for non-sexual and sexually violent recidivism. The review of the literature by McGovern and Peters (1988) also considered supervision failure to be an important factor to consider when evaluating level of risk.

B. Sexual offending

12. High density sexual offending

Boer *et al.* (1997b) define high density sexual offending as frequent acts of sexual violence occurring in a relatively short period of time. They consider this item to be a reliable risk factor for future sexual recidivism. Monahan and Steadman's (1994) theory of violent behaviour has established a history of violent offending as the most significant factor with regard to future offending. Hall's (1990) meta-analysis of treatment studies within North America found that past sexual offending was predictive of future sexual violence, and Mossman (1994) found past behaviour to be a robust long-term predictor.

Hanson and Bussiere's (1998) meta-analysis found the number of past sexual offences to be one of the most reliably associated factors for recidivistic sexual violence among prisoners and forensic outpatients. This finding has also been established in the recidivism research of Hanson (1997) and Quinsey, *et al.* (1995). High-density sexual offending is likely to reflect the presence of a sexual deviation or paraphilia and attitudes that support or condone sexual violence. This item supports the rule of 'behavioural consistency' and is an important factor to consider in the risk assessment of sex offenders (McGovern and Peters, 1988). In summary,

there is strong and consistent evidence that high density offending is a reliable factor to consider when assessing sex offenders.

13. Multiple sex offence type

Multiple sex offence type refers to a history of sexual acts that vary in terms of nature and victim selection. Boer *et al.* (1997b) suggest that the nature of the offence may vary along several dimensions, including type and degree of coercion used, and victim characteristics. This item has strong support in the literature. The reviews of Hanson (1997) and Hanson and Bussiere (1998) found that offenders who have committed multiple types of sex offences according to victim characteristics, level of contact with the victim, and victim selection (e.g. adult female, boy victim) are at increased risk for recidivistic sexual violence. Boer *et al.* (1997b) consider multiple sex offence type an important item to forecast the specific nature and severity of any future sexual violence in terms of nature and victim selection, type and degree of contact with victim, and nature and degree of coercion used.

McGovern and Peters (1988) found that the degree to which an individual targets different categories of victim is one of the most reliably associated risk factors for recidivistic sexual violence. Research conducted by Abel *et al.* (1988) on descriptive account of offence behaviour provided by sex offenders suggests that almost half of a sample of incest offenders had

abused children outside the family. There appears to be strong evidence supporting the inclusion of this item in assessing risk with sex offenders.

14. Physical harm to victim

Physical harm to the victim as a result of the offending is considered a risk factor with regard to recidivist sexual violence (Boer *et al.* 1997b). However, there is a lack of clear evidence that this factor predicts sexual violence (Hanson and Bussiere, 1998). This is a difficult risk factor to study because those convicted of serious sexual offences may be imprisoned for longer periods than other sex offenders. It is an important factor to consider as it gives an indication of the severity of sexual deviation and may suggest the presence of sexual sadism (Boer *et al.* 1997b). Professional reviews also consider this an important factor to consider when assessing sex offenders (McGovern and Peters, 1988).

15. Use of weapons or threats of death

As with 'physical harm to victim', the use of weapons or threats of death in sex offences is a difficult factor to study, as an offender using weapons or threatening the victim with injury or death during a sex offence is likely to be jailed for a longer period of time than an offender who does not use such threats.

In Sweden, Langstrom (1999) found that the use of weapons and death threats made at the time of the offence were predictive of general recidivism but not sexual recidivism amongst a cohort of 56 young sex offenders. Kahn and Chambers (1991) found that verbal threats during the index offence predicted sexual recidivism at follow-up with a group of 221 young child sexual abusers. This item may reflect the presence of a more serious sexual deviation and it is a useful factor to consider when predicting what type of victim is at risk and from what type of behaviour (Boer *et al.* 1997b). The clinical review of McGovern and Peters (1988) considers the use of weapons or threats of death to be an important factor to consider when conducting risk assessments with sex offenders. There is however no clear evidence from the meta-analysis of Hanson and Bussiere (1998) of the predictive power of weapon use or death threats when conducting assessments of risk of sexual violence.

16. Escalation in frequency or severity of sex offences

Boer *et al.* (1997b) consider an escalation in offence severity to be an important factor to consider during assessment. Greenland's (1985) observations of clinical work with juvenile sex offenders found that some offenders presented with a trajectory of offences towards more serious offending through the passage of time. Hanson and Bussiere's (1998) meta-analysis (1998) found no clear evidence that this factor reliably predicted sexual violence in the review of 61 North American recidivism studies.

Ross and Loss (1991) considered a history of progression in sex offence severity to be indicative of a higher risk offender in their review of juvenile sex offenders based on ten years of clinical experience. They defined escalation as a progression involving different offence types, and a history of consistent offence type with a progression of added behaviours.

Of interest is the finding of Quinsey *et al.* (1995) who observed that rates of sexual recidivism decreased with the seriousness of the index offence. This is consistent with research on recidivism rates and offence severity within Scotland (Mair and Stevens, 1994). Taken in summary, there appears to be strong evidence to support this item when applied to juvenile sex offenders. However, the significance of an escalation in the severity of sexual violence has not yet been established with adult sex offenders.

17. Extreme minimisation or denial of sexual offending

Denial is commonplace in the assessment of sex offenders. Boer *et al.* (1997b) state that extreme minimisation or denial of sexual offending is a risk factor with regard to clinical estimates of recidivism.

Langevin (1988) found that approximately 50 per cent of sex offenders denied or minimised their offending behaviour even following conviction. On the basis of interviews with 102 male sex offenders, Kennedy and Grubin (1992) found evidence to support four patterns of denial, including

men who denied harm to their victim, men who externalised responsibility for the offence, men who denied the extent of their sexual deviance, and the largest group, men who remained in total denial.

Sex offenders may not be open in the account of the offending during assessment. Many deny their involvement altogether while others minimise their involvement in an attempt to make the offence appear less serious. In a study with a group of 221 child sexual abusers, Kahn and Chambers (1991) found that denial or victim blame predicted sexual recidivism at follow-up. A review of the clinical literature by McGovern and Peters (1988) considered denial to be an important factor to assess with adult sex offenders. Ross and Loss (1997) support the validity of this item when conducting assessments of juvenile sex offenders. However, Hanson and Bussiere (1998) found no clear research evidence supporting this factor's ability as a predictor variable for risk of recidivism with adult sexual offenders.

Jackson and Thomas-Peter (1994) comment that it is difficult to envisage how reoffending can be significantly reduced until cognitive distortions and rationalisations for behaviour have been confronted. Salter (1988) has argued that denial is more of a spectrum than a single state. In summary, denial has clear relevance for the management of sex offenders although

there continues to be debate over the importance of denial as a risk factor for recidivism.

18. Attitudes which support or condone offending

Boer *et al.* (1995b) state that offenders who engage in criminal conduct frequently endorse cultural or personal attitudes that support their behaviour. The review of the literature by Andrews and Bonta (1994) found attitudes that support or condone offending to be associated with criminality in general. People who engage in criminal conduct frequently endorse attitudes that support their behaviour. However, Hanson and Bussiere (1998) found no clear evidence supporting the predictive ability of pro-criminal attitudes when assessing risk of future sexual violence. It is of note that research studies rarely examine or infrequently record attitudes during assessment despite the influence of pro-criminal sentiments for engagement in psychological intervention.

Hanson and Harris (1998) found that recidivist sexual offenders within North America held significantly more attitudes tolerant to sexual assault than non-recidivists. In Sweden, Schram *et al.* (1991) found cognitive distortions to be predictive of sexual recidivism amongst juvenile sexual offenders. Greer's (1991) clinical review of the literature on juvenile sex offenders found that beliefs or values that encourage sexual violence towards women or beliefs that support sexual contact between adults and

children are important when evaluating level of risk of recidivism. Grubin (1994) has identified fantasy as a salient indicator of sexual offending, while Prentky's (1995) review of the cost-effectiveness of treatment studies highlighted lack of empathy as a significant disinhibitor for sex offending.

In a small-scale descriptive study of offenders admitted to a regional secure unit over a twelve-year period, Chesterman and Sahota (1998) found similarities in cognitive distortions between the sample of mentally ill sex offenders and a community sample of non-mentally ill sex offenders. There appears to be strong clinical opinion and a lack of research evidence to support pro-criminal sentiments as a risk factor for recidivism.

C. Future plans

19. Lacks realistic plans

Andrews and Bonta's (1994) review of the literature found that a failure to devise suitable and realistic plans to be a factor associated with an increased risk for future violence and criminality. Proulx *et al.* (1997) suggested that a lack of realistic plans may lead to short term distress which may in some individuals increase the likelihood and frequency of future sexual violence. A failure to devise suitable and realistic plans is also discussed in reviews of the literature as having predictive utility with juvenile sex offenders (Ross and Loss, 1991).

In summary, several clinicians have cited the importance of considering realistic plans in assessing risk although there is an absence of research evidence to support the utility of realistic plans as a risk factor.

20. Negative attitude towards intervention

Individuals rejecting mental health support or exhibiting a negative attitude towards mental health treatment or supervision were found to be at increased risk for future violence and criminality by Webster *et al.* (1997). The review of treatment engagement by Jackson and Thomas-Peter (1994) found that levels of denial inhibit the ability to challenge the cognitive distortions and rationalisations for offending. Andrews and Bonta (1994) have indicated that offenders who reject treatment or who lack the motivation to make use of this support are at increased risk of recidivism. The meta-analysis of recidivism rates of sex offenders by Hanson and Bussiere (1998) found that refusal of treatment and dropping out of treatment predicted future sexual violence.

Hanson and Harris (1998) found that 76 per cent of their sample of 400 recidivists and non-recidivists had attended specialised sexual offender treatment programmes. The recidivist group was significantly more likely to have dropped out of treatment than the non-recidivists. Hanson and Bussiere (1998) found that failure to complete treatment was a modest predictor of sex offence recidivism in a meta-analysis. Professional reviews

also consider treatment failure an important factor to consider when conducting risk assessments (McGovern and Peters, 1988).

Summary

Boer *et al.* (1997a) present the SVR-20 from a theoretically derived perspective and recognise that no studies currently exist which have examined the effectiveness of the SVR-20 as a tool in clinical practice or for assisting predictions of risk. The current research is unique in that it is the first attempt to empirically validate the SVR-20 with a clinical population of non-contact and contact sexual offenders.

Psychopathy

> **"Psychopathic disorder is an unfortunate term with a disreputable history, but there us a group of patients for whom this or some equivalent nomenclature is required"** (Mullen 1992 - quoted in Cooke, 1997).

Psychopathic personality disorder is a form of personality disorder with a unique pattern of affective, interpersonal, and behavioural symptoms (Hare, 1991). Cooke (1997) comments that psychopaths exhibit a unique constellation of traits. Interpersonally psychopaths are grandiose and manipulative. Affectively, psychopaths display shallow emotions and are unable to form lasting bonds to people, principles or goals. They lack

empathy, and exhibit an absence of anxiety or genuine guilt and remorse. Behaviourally, psychopaths are impulsive and sensation seekers who often violate social norms. It is evident to mental health professionals within the criminal justice system that the expression of psychopathic traits in closely correlated with criminality.

The Hare Psychopathy Checklist (Hare, 1991).

The most systematic procedure currently available for assessing psychopathic personality disorder in criminal populations is the Hare Psychopathy Checklist - Revised (PCL-R; Hare 1991). The Hare PCL-R is considered to be the method of choice for assessing the presence of psychopathic personality disorder. The Mental Measurement Handbook (Conoly and Impara, 1995) stated:

"There is no doubt that the PCL-R is the "state of the art" in this area, both clinically and in research use " p. 454.

The PCL-R is a clinical construct rating scale usually based on a structured interview and a review of available collateral information. This method of evaluating personality has distinct advantages over the self-report approach of other popular measures of personality such as the Minnesota Multiphasic Personality Inventory (MMPI). Cooke (1997) suggested that self-report procedures require the individual to co-operate and there is a risk that certain individuals may attempt to falsify or exaggerate their responses. The

PCL-R minimises this risk by the reliance on multiple sources of information. Hare and Hart (1995) are also critical of existing self-report methods to evaluate personality in criminal populations. They also suggest that the Diagnostic and Statistical Manual of the American Psychiatric Association, DSM-IV criteria (APA, 1994) for Antisocial Personality Disorder neglects the interpersonal or affective characteristics of psychopathic personality disorder which are considered core features. They also comment that the DSM-IV criteria for antisocial personality disorder places too much focus on social deviance.

Structure of the Hare PCL-R (Hare, 1991)

The PCL-R is based on 20 characteristics which are traditionally considered to be central to the concept of psychopathy and derived from the early clinical descriptions of Cleckley (1976). The PCL-R manual provides extensive descriptive information to assist the accurate coding of each item. Each characteristic is rated to how well it matches the description in the PCL-R manual. The 20 items which constitute the PCL-R are as follows:

Items in the Hare Psychopathy Checklist-Revised (PCL-R)

1. Glibness/superficial charm
2. Grandiose sense of self-worth
3. Need for stimulation/proneness to boredom
4. Pathological lying
5. Conning/manipulative
6. Lack of remorse or guilt
7. Shallow affect
8. Callous/lack of empathy
9. Parasitic lifestyle
10. Poor behavioural controls
11. Promiscuous sexual behaviour
12. Early behaviour problems
13. Lack of realistic, long-term goals
14. Impulsivity
15. Irresponsibility
16. Failure to accept responsibility for own actions
17. Many short term marital relationships
18. Juvenile delinquency
19. Revocation of conditional release
20. Criminal versatility

from the Manual for the Psychopathy Checklist, Hare 1991

The PCL-R is divided into two related factors that assess the interpersonal and affective traits (Factor 1), and social deviance (Factor 2). Approximately half of the items cover interpersonal and affective traits such as callousness, remorselessness, and irresponsibility. The remaining items capture behavioural traits as reflected in the unstable, impulsive, and antisocial lifestyle.

Psychopathy and crime

Psychopathy is an important factor to consider in any study of recidivism with offenders for several reasons. First, psychopathy has been shown to be a salient factor for determining risk of violence and is established as one of the single best predictors of recidivism in violent offenders (Hart, 1996).

Second, contemporary research and clinical experience has demonstrated that offenders who exhibit a high degree of psychopathic personality disorder may not reduce their propensity to offend and this in turn influences decisions relating to risk assessment and management (Rice, Harris and Cormier, 1992). Third, psychopathy ratings made on the PCL-R are known to be important elements in actuarial risk assessments (Webster, 1994; Hart *et al.* 1995). As Cooke (1995) observed, the psychopath's propensity to violate social norms as a result of their dense and wide-ranging criminal behaviours often starts at an early age. Also, the traits of callousness and lack of empathy lead to a higher propensity to engage in violent behaviour, both within and outwith prison, and this anti-social behaviour persists to a much later age than non-psychopathic criminals (Hart *et al.* 1994; Hare *et al.* 1992).

Psychopathy and violence

Hare (1980) used a clinical global rating of psychopathy (preceding the PCL) to examine the violent behaviours of 243 male prison inmates and found that psychopaths were generally more violent than non-psychopaths. Specifically, 97 per cent of the psychopaths and 74 per cent of the other inmates had received at least one conviction for a violent offences.

Hare and Jutai (1983) compared the criminal behaviours of 97 psychopaths and 96 non-psychopaths also diagnosed using the clinical global rating scale

over the course of one year. They found that rate of violent offending was more than three times higher for the psychopaths than non-psychopaths (91 per cent and 27 per cent respectively).

Wong (1984) analysed the criminal records of a random sample of 315 male inmates from minimum, medium, and maximum-security institutions in Canada using the PCL to discriminate between a psychopathic and non-psychopathic group. He found that psychopaths committed more than twice as many offences per year and almost nine times as many institutional offences as non-psychopaths. He also found that psychopaths committed almost four times as many institutional offences and engaged in significantly more threatening behaviours and acts of violence than did non-psychopaths. A further finding was that psychopaths had their first formal contact with the law at an earlier age in comparison with non-psychopaths.

Hare *et al.* (1988) examined the careers of two criminal groups defined as either psychopaths or non-psychopaths using the PCL-R. They distinguished between general recidivism and violent recidivism. The frequency of non-violent crime amongst the psychopathic group was substantially higher than amongst the non-psychopathic group throughout the life stages, diminishing by the fourth decade. In contrast the rate of violent crime did not disappear. Evidence from this study suggested that a

psychopaths future convictions for general crime may diminish over time. However the propensity for violence was maintained.

Hart *et al.* (1988) rated a sample of 221 men using the psychopathy checklist who were then released from federal prison in Canada to predict rates of criminal recidivism following release. The men were rated as non-psychopaths (with scores below 20 on the PCL-R), moderate psychopaths (with scores between 20 to 29), and psychopaths (who scored 30 or above). After one year the rate of recidivism for the low group was 20 per cent, the moderate group was 47 per cent, and the high group was 62 per cent. After three years the rate of recidivism for the non-psychopaths was 29 per cent, the moderate psychopaths was 62 per cent, and the psychopaths was 82 per cent. The researchers found that re-offending could be reliably predicted and also that the psychopathic group had more partners, had less stable employment, and spent significantly longer on welfare than the other groups.

In combination, these studies demonstrate a strong association between psychopathy and an increased risk for criminality in general and violence in particular with male offenders. Many other studies exist which replicate the post-dictive validity of the psychopathy checklist and the predictive reliability following release from prison or hospital (Forth, Hart and Hare, 1990; Serin, 1991; Hart, Kropp and Hare, 1988; Hare, 1985; Serin, Peters and Barbaree, 1990; Forth *et al.* 1990).

There has not been unanimous agreement on the PCL-R although objection appears to reflect both moral and semantic issues rather than the predictive properties of the scale. Blackburn (1988) argued that much confusion stems from the use of the term 'psychopath' when used within a clinical or legal framework both within the United Kingdom and North America. Blackburn has also objected to the term 'psychopath' as a 'moral judgement masquerading as a clinical diagnosis' due to the definition of psychopathy being primarily constructed on the basis of socially deviant behaviours.

Cavadino (1998) has commented that the term 'psychopath' stigmatises patients and scares the public with a label that lacks scientific and jurisprudential legitimacy. He suggests that psychopathy remains a stereotype rather than an accurate description of any real individual. The research and clinical literature appears overwhelmingly to demonstrate that if psychopathy is a stereotype, it is a clinically useful one.

Psychopathy in Scotland: cross-cultural variation

Little has traditionally been known about the cross-cultural variation in either the prevalence or nature of psychopathy within United Kingdom samples as the majority of studies using the PCL-R or its predecessors have been based on adult male offenders in North America. The few studies that had been reported are based on small and frequently unrepresentative

samples (Raine, 1985, Cooke, 1989). A recent study by Shine and Hobson (1997) used the PCL-R with a sample of 104 inmates admitted to Grendon Prison for long-term psychotherapy and found a 26 per cent prevalence rate of psychopathy. This result is close to levels of psychopathy reported in North American prison settings. The result should be interpreted with caution and is unlikely to reflect an accurate estimate of psychopathy within the English prison system due to the selection criteria for Grendon which requires the presence of a 'personality disorder' or 'psychopathy' as a prerequisite.

Between 1989 and 1990, Cooke (1994) obtained ratings on a sample of 310 Scottish prisoners as part of a larger study into the rate, nature, and causes of psychological disturbance amongst prisoners within the Scottish Prison system. Data analysis revealed that the level of psychopathy was surprisingly low, indicating that three per cent of the adult male prisoner population within Scotland met the PCL-R criterion for psychopathy. This compared with 23 per cent of North American Prisons (Hare, 1991) and prompted the question:

"where have all the Scottish psychopaths gone?" p. 13. Cooke (1997).

Cooke (1995) used Classical Test Theory (CTT) and observed that differences in prevalence rates in psychopathy between Scotland and North

America could not be attributed to differences in functioning of the PCL-R items. The factor structures were essentially identical to the factor analysis of the North American data. In a further study Cooke and Michie (1997) used Item Response Theory (IRT) to examine PCL-R scores between a Scottish prisoner sample of 310 and a North American sample of 2067.

The suggestion by the researchers was that Scottish prisoners had to have higher levels of the disorder before many of the characteristics became apparent. Cooke and Michie suggested that a lower diagnostic cut-off of 25 should be used in Scottish prisons as opposed to the North American diagnostic cut-off of 30. Even with the revised cut-off, only eight per cent of Scottish prisoners meet diagnostic criteria for psychopathy. The speculative suggestion is that psychopaths may seek excitement and opportunities in the south of England. It may also be that the prevailing Scottish culture is less supportive of psychopathic behaviour and the expression of traits such as superficial charm and parasitic behaviour.

The Hare Psychopathy Checklist: Screening Version (Hart *et al.* 1995)

Cooke *et al.* (1999) observed that administration of the PCL-R was time intensive and required access to detailed interview and case history information. It is also costly to administer in terms of time and effort. The Psychopathy Checklist: Screening Version (PCL:SV - Hart *et al.* 1995) is a 12 item clinical construct rating scale derived from the items of the PCL-R.

The item descriptions in the PCL:SV manual are brief in relation to those in the PCL-R manual and require less detailed information to score. The items of the PCL: SV compared to the PCL-R are as follows:

PCL:SV item	PCL-R item
Part 1	
Superficial	1
Grandiose	2
Deceitful	4, 5
Lacks remorse	6
Lacks empathy	7, 8
Doesn't accept responsibility	16
Part 2	
Impulsive	3, 14
Poor behavioural controls	10
Lacks goals	9, 13
Irresponsible	15
Adolescent antisocial behaviour	12, 18
Adult antisocial behaviour	19, 20

The PCL: SV items are rated on the same 3-point scale used for the PCL-R and are summed to yield total scores ranging from 0 to 24. A cut-off of 18 or greater is used to diagnose psychopathy. The screening version is correlated highly with the PCL-R in several samples, even when the scales were administered on separate occasions by independent raters. Using Item Response Theory, Cooke *et al.* (1999) found the PCL:SV to be an effective short form of the PCL-R. The research of Cooke (Cooke, 1995; Cooke,

1998; Cooke *et al.* 1999; Cooke and Michie, 1997) on the cross-cultural validity of the PCL-R and the PCL:SV strongly suggest that the measure can be validly used within Scotland.

Psychopathy and sexual offending

Given the characteristics of psychopathy, including lack of empathy, sexual promiscuity, conning and manipulative behaviour, and impulsivity, it is reasonable to expect psychopathy to be a strong predictor of sexual violence. The majority of studies using the PCL-R to predict sexual recidivism have been completed within North America.

Several studies have demonstrated the importance of psychopathy in forecasting recidivism with sex offenders. Rice, Harris and Quinsey (1990) studied 54 rapists released from a maximum-security psychiatric hospital. During the follow up period that averaged 46 months, 28 per cent of the patients committed a sexual offence and 43 per cent committed a violent offence (all sexual offences were also coded as violent). Psychopathy scores were strongly related to post-release sexual offences, and a combination of psychopathy and phallometric measures of sexual arousal, as assessed by penile plethysmography, was as effective as predicting sexual offences from a battery of demographic, psychological, and criminal history variables.

Rice and Harris (1997) extended the above study to assess a number of demographic and criminogenic variables by file review of a total sample of 288 sex offenders including 142 sex offenders against children and 88 rapists. Fifty-eight subjects met both criteria. The sample was followed for an average of 10 years to determine rates of sexual recidivism, defined simply as whether the subject had been charged with a new sexual offence during the follow-up period. Overall recidivism rates were high with 101 men (35 per cent) committing a new sexual offence. Higher rates of recidivism were noted for homosexual sex offenders against children and having multiple victim categories consistent with the preliminary clinical findings suggesting that victim crossover may also occur in UK sample (Beckett *et al.* 1997). Those subjects scoring highest on measures of sexual deviance and psychopathy as assessed by the PCL-R were shown to have the highest rates of violent recidivism.

The above studies have not found large direct relationships between psychopathy and sexually violent recidivism, although the studies found high rates of sexual offence recidivism amongst those offenders who were rated highly on both psychopathy and sexual deviance. There are no studies to the author's knowledge that have used a measure of psychopathy specifically to assess non-contact and contact sex offenders within Scotland.

Sex offending in Scotland

The Scottish Office Classification of Crimes and Offences divides crimes of indecency into three categories. In 1996 there were 546 convictions for crimes of indecency. There were 123 sexual assault convictions, which comprise of rape, assault with intent to rape, and indecent assault. There were 295 charges of lewd and indecent behaviour, which comprise of lewd and indecent practices against children and indecent exposure; and 128 other sexual offences, which comprise of offences connected with prostitution, incest and sexual intercourse with girls under 16 years of age. The total number of crimes of indecency represents approximately one per cent of all crimes and offences within Scotland.

It is apparent that there are enormous health and economic implications of sex offending within Scotland. The costs of sexual offending might be considered in terms of personal costs to the victim and costs to society at large. The long-term psychological impact to the victim includes problems with self-esteem, personality disorder, suicidal behaviour, sexual problems, and substance abuse. The costs incurred to society might be medical and health resources provided to the victim to assist recovery, the legal costs associated with re-offending, and the cost of imprisoning a sexual offender, often in a segregated unit or special hospital facility.

Waterhouse *et al.* (1994) studied the records of 500 known sex offenders against children within Scotland to ascertain the nature and circumstances of child sexual abuse. They found that 99 per cent of child sex abusers are male and the majority of offenders are known to their child victim frequently as the fathers or stepfathers of the children, or friends of the family. Only one in ten of the sex offenders against children were strangers. Three quarters of abused children within Scotland were female and the majority of children were under the age of 12 years old when the abuse began (Waterhouse *et al.* 1994).

Non-contact and contact sexual offending

While the study of Waterhouse *et al.* (1994) has presented relatively specific descriptions of discrete groups of sexual offenders, other researchers have argued that the nature of deviant sexual behaviour may best be quantified by a simple 'hands-on' and 'hands-off' classification (Mair and Stevens, 1994; Sugarman, 1994). These terms have been used interchangeably with the terms 'contact' and 'non-contact' offending. The term 'non-contact' refers to those offenders whose behaviour is characterised by sexual offending without any physical contact with the victim. The term 'contact' refers to those individuals who have made physical contact with the victim as part of their offending behaviour.

Few predictive studies have been undertaken amongst non-contact sexual offenders because these individuals are traditionally seen as 'generally harmless' (West, 1987). Hanson and Harris (1998) excluded non-contact offenders from their research on dynamic predictors of sexual recidivism. This is a concern given that non-contact offender have the highest rates of recidivism (Mair and Stevens, 1994). Also Abel *et al.* (1988) found the co-occurrence of paraphilias (forms of sexual deviancy) including non-contact offending to be 93 per cent.

Exhibitionism has been found to be the most common type of non-contact sexual offending and the most common type of sexual offending in general (Snaith, 1983). His clinical case reports suggest that progression from non-contact sexual offending to more serious sexual offending is the exception rather than the rule. The few predictive research studies that have been undertaken amongst male non-contact offenders conclude that exhibitionists do not generally gravitate towards more serious sexual crimes (Gebhard 1965; West 1987). Contemporary opinion on sex offending in Scotland suggests that non-contact offending is masturbatory and unlikely to lead to more intrusive types of contact sexual offending (Mair, 1994).

Clinical experience with a range of sex offenders referred to the Douglas Inch Centre for assessment and treatment suggests that some non-contact offenders recidivate with more serious contact sexual offending. Among

Gebhard's (1965) sample of 135 cases, approximately one-fifth of non-contact offenders gravitated towards sex offending involving physical contact. Gebhard (1965) estimated that ten per cent of the sample were actual or potential rapists. In addition, many serious sex offenders have previous convictions for indecent exposure. Walker and McCabe (1973) cited a number of case studies to demonstrate that half of the indecent exposers in their sample had a previous conviction for indecent assault.

Mair and Stevens (1994) conducted a follow-up study of the offending histories and offending behaviour of 75 sex offenders within Scotland over a ten-year period. The sample consisted of sex offending behaviour ranging from obscene telephone calling to rape. A distinction was made between contact and non-contact offending. They found that non-contact offenders had a higher prevalence of sexual convictions both before the index offence and over the ten-year follow-up period. In addition, they noted that offenders who exhibited the highest level of intrusiveness in their offending behaviour had the lowest level of sexual recidivism.

Mair and Stevens commented that exhibitionists have a relatively high rate of sexual recidivism. They noted that one quarter of the sample of sex offenders had identifiable previous sexual convictions prior to the index offence, while 54 per cent had previous convictions for any offence. However this has not lead to a more general interest in the predictive value

of the type of act committed by the offender. Mair (1993) also found that imprisoned rapists were less likely to have histories of repeated sexual convictions than those who had not whether their victims were adults or children.

It is sometimes assumed that offending behaviour escalates over time thus any one sexual offence cannot have predictive significance. Sugarman *et al.* (1994) examined the psychiatric and medical case notes of 210 genital exposers referred to a Forensic Psychiatric Service. Criminal records were accessed from the Home Office for a follow-up period ranging between 8 and 25 years. Generally they found the prediction of dangerousness in exhibitionists to be feasible, with 26 per cent of the sample accruing at least one conviction for a contact sexual offence.

Sugarman and colleagues found that exhibitionists who gravitated towards contact offending were significantly more likely to have a history of childhood conduct disorder, convictions for acquisitive offending, excessive libido, homosexuality, exhibiting at more than one site, cornering or pursuing the victim, and being assessed as having an unfavourable prognosis. Weak statistical associations were noted for contact sexual offending and displaying an erection, exposing to younger victims, and speaking to victims. No association between escalation from non-contact to

contact offending was noted for a subject's history of substance abuse, or having been the victim of abuse as a child.

Several these findings run contrary to the extensive and widely cited meta-analysis of sexual offender recidivism studies completed by Hanson and Bussiere (1998). Sugarman *et al.* (1994) noted limitations to their study including difficulties accessing data due to unsystematic case note recording over many years in day-to-day clinical practice. While suggesting that accurate empirical prediction of serious offending in exhibitionists is possible, Sugarman and colleagues concede that the results should be interpreted with caution. In addition, the correlational analyses used in this type of study has been found to be misleading when assessing the clinical usefulness of risk factors (Cooke, 1994). There continues to exist a clear need for clinicians to be able to establish which non-contact offenders gravitate towards more serious crimes of sexual violence.

Other considerations

It has long been established that criminal history variables including age at first offence and number of prior convictions are good predictors of re-arrest in both juvenile and adult offenders (Martinson and Wilks, 1976; Selling and Wolfgang, 1964). Early research by Amir (1971) suggests that this relationship holds for sexual offending although the recent meta-analysis conducted by Hanson and Bussiere (1998) found only a modest

correlation. Furby *et al.* (1989) noted that the number of prior arrests is not a particularly good estimate of the absolute level of criminal behaviour although it is a useful measure when evaluating the comparability of different groups. There is a need to clarify the issue of age at first offence and likelihood of escalation with respect to sex offence severity.

There are several areas reported in the literature as risk factors which are not covered by the SVR-20. They may have strong clinical support but have been examined or recorded infrequently during assessment and have therefore yet to be adequately researched. Hanson and Scott's (1996) study of social networks, found that association with other sex offenders was a risk factor increasing the likelihood of future sexual violence in a cohort of sexual offenders. This has not been established in any other study and this factor will be examined to estimate whether an association with other sex offenders is a factor discriminating between non-contact sexual recidivists and contact sexual recidivists.

Homosexuality and sexual offences against boy victims are considered to be risk factors for future sexual violence in a number of clinical case studies and professional reviews (Barbaree & Marshall, 1989; Hanson & Bussiere, 1996; Quinsey, 1986). Jehu (1991) has commented that sexual offenders against males should not necessarily be considered homosexual. Newton (1978) has also suggested that a number of sex offenders against boys may

be paedophiles with no interest in adult males. In a review of the literature, Quinsey *et al.* (1995) found that homosexual paedophiles had the highest rate of prior convictions for sexual crimes and the highest rates of reconviction. However this factor is not covered by the SVR-20 due to authors concern that no item should be discriminatory by race or sexual orientation (Boer *et al.*, 1997). Sugarman *et al.* (1994) found that homosexual activity was strongly associated with contact sexual offending rather than non-contact offending and suggested that homosexuality may sometimes be associated with more serious sex offending. There is a need to establish whether homosexual offending discriminates between non-contact recidivists and contact recidivists.

Recent attempts have been made to establish whether a 'type' of offender will 'cross-over' in their offending between intra and extra-familial abuse, victim's gender and victim age characteristics. The extensive work of Abel *et al.* (1987) found that sexual offenders disclosed a high level of crossover. Quinsey *et al.* (1995) found that factors associated with recidivism in one major category of offenders also predict recidivism in another. Preliminary accounts suggest that crossover may also occur in UK sample and may be an important risk factor to consider when conducting a risk assessment (Beckett *et al.*, 1997) although there has been no specific research assessing patterns of crossover.

Summary

Segal and Marshall (1985) have advocated a multi-variable model to determine risk factors in sex offending due to the low likelihood of explaining variance between groups from a single variable. There exists a need to examine multiple factors to determine those with adequate power to discriminate between sexual offenders who remain at risk of further non-contact sexual offences and who do not escalate in terms of offence severity (non-contact recidivists), from those sexual offenders who gravitate from non-contact sexual offending to more intrusive contact sexual offending (contact recidivists). This method of examining multiple variables has considerable support in the research conducted on sex offending to date (Hanson and Bussiere, 1998). The SVR-20 is derived from a theoretical perspective and no studies currently exist which have examined the effectiveness of the SVR-20 as an assessment method in clinical practice. The current research is unique in that it is the first attempt to empirically validate the SVR-20 with a clinical population of non-contact and contact sexual offenders. The above empirical and clinical reviews have not found large direct relationships for psychopathy and sexually offending, although they report high rates of sexual offence recidivism amongst those offenders who rated highly on both psychopathy and sexual deviance. There is a need to examine the utility of the PCL: SV specifically to assess non-contact and contact sex offenders within Scotland. Consideration is also given to those

items that are considered significant factors associated with sex offending in the literature but not included in the SVR-20.

Overall, the current study is intended to follow the guidelines of Hanson and Bussiere (1998) who suggested that:

> **"Today's clinicians can contribute to future research by carefully assessing and recording the factors that are considered important for risk assessment but have yet to be adequately researched".** p 358

Aims of the study

There are a number of specific aims and principles guiding the research. The first is to establish factors that significantly discriminate between non-contact recidivists and contact recidivists on the Sexual Violence Risk –20. The second is to establish factors that significantly discriminate between non-contact recidivists and contact recidivists on the Psychopathy Checklist: Screening Version. A third aim is to establish whether criminal history variables significantly discriminate between non-contact recidivists and contact recidivists. The fourth is to establish whether psychosocial variables including an association with other sex offenders and homosexual offending significantly discriminates between non-contact recidivists and contact recidivists. The research is also aimed at establishing whether custodial and treatment variables, including a previous prison sentence and a previous history of psychosexual treatment, discriminate between non-contact recidivists and contact recidivists. A final aim is to establish whether patterns of crossover discriminate between non-contact recidivists and contact recidivists.

The current research is also motivated by two general principles based on clinical experience with sex offenders and their victims. First, there is a need for psychologists to be able to reliably assess sex offenders to protect the public from recidivists whose behaviour potentially places others at a significant risk. Second, there is a need to determine the level of psychological intervention required or level of supervision to meet the needs of the sex offender in line with evidence-based assessments of their potential to escalate with regard to offence severity.

Hypotheses

Hypothesis 1.

Contact recidivists will exhibit significantly higher levels of sexual deviation than non-contact recidivists.

Hypothesis 2.

Contact recidivists will exhibit significantly higher levels of childhood victimisation than non-contact recidivists.

Hypothesis 3.

Contact recidivists will exhibit significantly higher levels of psychopathy than non-contact recidivists.

Hypothesis 4.

Contact recidivists will exhibit significantly higher levels of major mental illness than non-contact recidivists.

Hypothesis 5.

Contact recidivists will exhibit significantly higher levels of non-sexual violent offending than non-contact recidivists.

Hypothesis 6.

Contact recidivists will exhibit significantly higher levels of general non-violent offending than non-contact recidivists.

Hypothesis 7.

Contact recidivists will have committed significantly more homosexual offences than non-contact recidivists.

Hypothesis 8.

Contact recidivists will be significantly younger at age of first offence than non-contact recidivists.

Hypothesis 9.

Contact recidivists will have had significantly more associations with other sex offenders than non-contact recidivists.

Hypothesis 10.

Contact recidivists will have had significantly higher levels of sex offence crossover than non-contact recidivists.

Method

The gold standard for evaluating any risk assessment scheme is to conduct a long-term follow up of a large sample of sex offenders who are released into the community after being evaluated with the SVR-20 and PCL:SV. The problem is that base rates of officially detected sexually violent recidivism are low and may be as low as 30 per cent to 50 per cent over 25 years (Rice and Harris, 1997). Base rates have a profound effect on the accuracy that can be achieved in prediction. Quinsey *et al.* (1995) commented that if the base rate is low then the best prediction for any offender in that group is that they will not re-offend. The converse holds true for a population with an extremely high base rate where the best prediction is that every one will offend.

Societal considerations usually play a major role in selecting the sample of sex offenders to be studied. Where a long-term follow up of a large sample of sex offenders who are released into the community is not possible or desirable, a compromise for evaluating accuracy of risk factors has to be reached. One method is to conduct a follow-back or retrospective-prospective comparison study of sex offenders. The major disadvantage of this type of methodology is that subjects included in the research are those offenders who recidivate with a criminal conviction. This may mean that the results are generalisable only to other sex offenders who are convicted.

There are advantages to a retrospective-prospective comparison as a research method. Furby *et al.* (1989) commented that retrospective sexual recidivism studies can be helpful for two reasons. First, they can assist in the design of prospective studies by providing information about psychometric properties of measures and the magnitude of change expected on various criteria. Second, the results can be available within months, in contrast to the many years that it takes to process subjects through all phases of prospective evaluation.

The method employed in the current study is a retrospective comparison of non-contact sexual recidivists and contact sexual recidivists. This design has been successfully employed by Quinsey and others (1995) in their research on risk factors for mentally disordered offenders who recidivate and those who do not. Hanson and Harris (1998) also reviewed dynamic predictors of sexual recidivism between a group of 400 recidivist and non-recidivist offenders. The advantage of this type of study is two-fold. First, a retrospective study is less complex and expensive to conduct. Second, a retrospective study provides an optimal base rate of sexual violence since recidivism is 100 per cent.

Setting and data sources

The Douglas Inch Centre is unique in being the only multi-disciplinary forensic outpatient clinic in Scotland. The clinical staff consists of clinical psychologists, forensic psychiatrists, and a social worker. Referrals are received from a variety of sources including the Sheriff and High Courts throughout Scotland, criminal defence

lawyers, Social Work departments, general practitioners and mental health professionals across Greater Glasgow Health Board NHS Trust and beyond.

Extracting data from file review

Cases had to satisfy the following preliminary criteria for inclusion into the study; (1) male; (2) a schedule of criminal convictions from the Scottish Criminal Records Office; (3) a history of sexual offending on at least two occasions; (4) a first sexual conviction for non-contact sexual offending; (5) case file material sufficient to score the measures, which included, but was not limited to, previous psychological and/or psychiatric reports, social enquiry reports, and other reports. All subjects included in the study had been interviewed on one or more occasions by a psychologist and/or psychiatrist at the Douglas Inch Centre and/or as a remand prisoner within the Scottish Prison Service.

Hall's (1990) meta-analysis of treatment outcome of sex offender programmes found that assessment and research with sex offenders should not rely on self-report alone. Studies based on corroborative sources of information and official records increase the reliability and validity of the results. Boer *et al.* (1997a) commented that while there are advantages to a study design based on file review, this type of research is limited by the nature and quality of the information contained in the files. The presence of corroborative information is essential when completing the PCL: SV as the absence of reliable data may compromise the measure. The PCL: SV manual notes that:

The PCL: SV should NOT be completed in the absence of file or collateral information (Hart *et al.* 1995) p. 18.

Sufficient case material was an essential feature in this study. A psychologist and/or psychiatrist had assessed all cases on one or more occasions. The majority of cases had been assessed by the author and assessed at the time of interview using the SVR-20 and the PCL-R or PCL: SV. The presence of previous convictions was noted using the protocol provided by the Scottish Office Home and Health Department to record conviction or offence type.

Subjects

A total of 40 subjects were included in the present study. Subjects were drawn from case files of sex offenders stored at the Douglas Inch Centre between the years of 1999 and 1996. Pre-1996 files were not readily accessible and therefore not included in the study. Cases had to have the minimum requirements of sufficient case material and criminal records. The number of files lacking sufficient case material to enable accurate coding exceeded the total numbers of offenders meeting the criteria for inclusion in the study.

A total of 40 sex offenders were included in the study, representing two groups of 20 male recidivist sexual offenders who had been referred to the Douglas Inch Centre for assessment and satisfied inclusion criteria. One group of 20 contact offenders had

a first conviction for a non-contact sexual offence and recidivated with a contact sexual offence. A second group of 20 had a first conviction for a non-contact sexual offence and recidivated with a further non-contact sexual offence between 1996 and 1999.

Subjects were classified into two groups of non-contact or contact recidivists. The term **'non-contact recidivists'** refer to those sexual offenders whose first offence was a non-contact sexual offence(s) and who subsequently recidivated with a further non-contact sexual offence(s) only. The term **'contact recidivists'** refer to those sexual offenders whose first offence was a non-contact sexual offence(s) and who subsequently committed a contact sexual offence(s). There had to be clear evidence of at least two previous convictions for a non-contact sexual offence to be included in the non-contact recidivist group. A previous conviction for a non-contact sexual offence and a subsequent conviction for a contact sexual offence were necessary for inclusion into the contact recidivist group.

This methodology goes further than Quinsey *et al.* (1995) who classified subjects based on 'clinical records of actual or attempted sexual offences' and not all subjects in Quinsey's study had a conviction for sexual offending. However, Mulvey and Lidz (1993) have argued that measures of aggressive behaviour should be derived from official records, semi-structures interviews, and from collateral reviews to reduce the dependence on arrest as indicators of aggressive behaviour. A further problem with the Quinsey study was that a number of convictions for non-sexual violent failures

were coded as sexual.

Research instruments

1. The Sexual Violence Risk-20 (Boer *et al.* 1997b)

The SVR-20 isolates clinical and empirical factors reported in the literature that are associated with recidivistic sexual violence in sex offenders. Ratings for each of the 20 items are made on a three-point scale according to the guidelines contained within the SVR-20 manual (Boer *et al.* 1997b). The manual recommends that '-' is used to indicate that information is not consistent with the intent of the item; '+' is used to indicate the presence of sufficient information consistent with the item; and '?' is used where there is some evidence but where the evidence is insufficient to fully support the item.

The authors do not recommend using the risk factors of the SVR-20 as an actuarial scale when making predictions of risk in any given case (emphasis added). The present research used a different scoring method from that suggested in the manual, and employs a more simplistic numerical coding. Items were coded '-' as 0; '+' was coded as 2; and '?' was coded as 1. This facilitated a score to be derived from the SVR-20 and made the result amenable to statistical comparisons between groups. The 'actuarial' method of scoring the SVR-20 is based on individual item scores and overall score. The 'clinical' method allows only a global rating of 'low' 'moderate' or 'high' to be obtained. The advantage of the actuarial method of scoring is the

ability to check the inter-rater reliability of the individual SVR-20 items and total scores on the SVR-20.

Preliminary accounts which use the SVR-20 as a research tool have found that the SVR-20 can be reliably scored as an actuarial measure (Dempsey, 1999). Also, Boer *et al.* (1997b) actively encourage the SVR-20 to be used for research purposes.

2. The Psychopathy Checklist: Screening Version (Hart, *et al.* 1995)

The Psychopathy Checklist: Screening Version (Hart *et al.* 1995) is a 12 item clinical construct rating scale based on clinical interview and/or a review of available collateral information. Each item is rated according to how well it matches the description of characteristics contained within the PCL: SV manual of prototypical psychopathic traits. A score of 0 indicates that the description does not apply. A score of 1 indicates that there is a partial match between the subject's characteristic and the information in the scoring manual. A score of 2 indicates the presence of a good match on the essential features of that item.

The PCL: SV has 12 items and the maximum score is 24. Scoring criteria contained within the manual suggest that a score of 18 or greater is indicative for diagnostic purposes of psychopathy. Scores of 12 or below are indicate of non-psychopaths. Scores of 13 to 18 are indicative of psychopathy. Although it is possible that the underlying construct is categorical, PCL: SV scores provide a useful indicator of the number of psychopathic traits and behaviours presented by an individual.

Cooke and Michie (1997) performed an IRT analysis on the PCL-R and suggested that a lower diagnostic cut-off of 25 should be used in Scottish prisons as opposed to the North American diagnostic cut-off of 30. Scottish norms for the PCL: SV are not available and the North American scoring has been adopted in this study. The extensive research of Cooke (Cooke, 1995; Cooke, 1998; Cooke *et al.* 1999; Cooke and Michie, 1997) on the psychometric properties and cross-cultural validity of the PCL-R and the PCL: SV strongly suggests that the SVR-20 can be reliably used within Scotland.

The PCL-R (Hare, 1991) has consistently been found to have good validity and reliability in a number of North American studies (Kosson *et al.* 1990). Wong (1988) found that psychopathy ratings based on file review were virtually identical to ratings that included both file review and interview. Use of the psychopathy checklist through file review alone has also been shown to yield acceptable predictive validity and the same psychometric properties as the conventional method of scoring in a number of North American studies (Harris, Rice and Quinsey 1995; Hanson and Harris, 1998) and European studies (Strand *et al.* 1999; Grann *et al.* 1998).

Coding sheet

A coding booklet (see appendix) was designed to accurately record the research variables identified from the literature review. The coding booklet contained the

SVR-20 and the PCL: SV. The booklet also contained items relevant to patterns of victim type, victim crossover and sex of victim. Information concerning association with other sex offenders and prior history of custody was also recorded. Where an offender had committed offences of a non-sexual nature, these were recorded in accordance to the Scottish Office Home and Health Department guidelines for offending categories.

Results

Statistical analysis was performed using the Statistical Package for the Social Sciences Version 6 (SPSS Inc. 1995). A *t* test was used for variables that were parametric in nature and a Mann-Whitney was used for non-parametric variables.

Bryman and Cramer (1999) indicated that the Mann-Whitney test should be the statistical test of choice where the data for two or more groups is non-parametric, for determining the differences between means where the assumptions underlying parametric tests cannot be met, and for a two condition unrelated design when different subjects are used for each of the conditions.

The Mann Whitney test compares the number of times a score from one of the groups is ranked higher than the other group. Bryman and Cramer (1999) argue that it is only appropriate to use parametric tests when the data fulfil the following three conditions: (1) the level or scale of measurement is of interval or ratio scaling; (2) the distribution of the population scores is normal; (3) the variances of both variables are equal or homogeneous. The psychological measures used in this study are not measured on an interval scale. This does not meet condition (1). Second, the groups used in this study have been drawn from populations that do not assume normal distribution or equal variances. This does not meet condition (2) or (3). It is also desirable to use non-parametric tests where the size of the samples is small (Bryman and Cramer, 1999).

Stevens (1946) has argued that parametric tests should only be used on interval/ratio data. Others have considered this restriction unnecessary. Siegel and Castellan (1998) consider the Mann Whitney to be about 95 per cent as powerful as the *t* test. This may mean that the *t* test requires fewer participants than the Mann-Whitney test to reject the null hypothesis when it is false. A *t* test was performed on the same variables as those considered for the Mann-Whitney test. This indicated the same significant differences between the groups as found using the Mann-Whitney test.

Inter-rater reliability

The first result concerns the inter-rater reliability of the SVR-20 and PCL: SV. Inter rater reliability was checked on four cases (10 per cent) randomly allocated from the total sample. A Clinical Psychologist with experience in forensic settings and prior training on the measures completed the SVR-20 and PCL: SV on four cases by file review. Kendall's *Tau* (τ) was considered to be the appropriate statistical test according to similar studies evaluating inter-rater reliability (Belfrage, 1998). Belfrage (1998) has commented that Kendall's τ is the appropriate method to calculate inter-rater reliability between not more than two assessors. Table 1. Illustrates Kendall's τ for the SVR-20 and PCL: SV.

Table 1. Inter-rater Reliability of SVR-20 and PCL: SV total scores and factor scores for four cases.

Measures	Kendall's τ	Significance
SVR-20 Total	$\tau = 1.000$, n = 4	0.042*
SVR-20 Part A: Psychosocial Adjustment	$\tau = 1.000$, n = 4	0.042*
SVR-20 Part B: Sex Offences	$\tau = 1.000$, n = 4	0.042*
SVR-20 Part C: Future Plans	$\tau = 0.1826$, n = 4	0.1826
SVR-20 Summary Risk Rating	$\tau = 1.0000$, n = 4	0.083
PCL: SV Total Score	$\tau = 0.6667$, n = 4	0.174
PCL: SV Part 1	$\tau = 0.6667$, n = 4	0.174
PCL: SV Part 2	$\tau = 0.6667$, n = 4	0.174

*at $p<.05$ level.

Table 1 suggests a modest level of inter-rater reliability between raters on the SVR-20 Total Score, SVR-20 Part A: Psychosocial Adjustment, and SVR-20 Part B: Sex Offences. Statistically significant agreement between raters was not achieved on the SVR-20 Summary Risk rating on all four cases. Poor inter-rater reliability was achieved for 'Future Plans'. Statistically significant agreement between raters was not achieved for PCL: SV Total or Factor ratings.

Absolute agreement was achieved for the Summary Risk rating of the SVR-20 with both raters agreeing in each case on whether level of risk was 'Low', 'Moderate', or 'High' and this is reflected in a Kendall's τ of 1.00. Belfrage (1998) found that a Kendall's τ of 0.6 or above to be consistent with a high inter-rater reliability of 43 cases and Hart et al. (1994) found an inter-rater reliability of 0.61 during the development of the PCL: SV. The results suggest that inter-rater reliability was above these limits in each case except for SVR-20 Part C: Future Plans. The failure to achieve statistical significance for the PCL: SV Total and Factor scores may reflect the small number of cases despite a Kendall's τ of 0.6 or above.

The second results concern the differences between non-contact recidivists and contact recidivists on measures of age and age at offending (Table 2. below)

Table 2. Age and age at offending between non-contact recidivists and contact recidivists.

	Non-contact Recidivists			**Contact Recidivists**			Statistical significance
		n=20			n=20		
	Mean	SD	Range	Mean	SD	Range	
Age	37.76	13.96	18-63	34.10	14.83	18-69	n.s.
Age at first non-sexual offence	29.30[1]	8.85	17-43	22.00[2]	7.12	13-37	p=0.044*
Age at first sexual offence	25.20	9.47	15-46	24.15	10.43	14-53	n.s.

1 n=10

2 n=12

* at p<.05 level

Table 2. shows age and age at offending for non-contact recidivists and contact recidivists. There were no significant differences observed between non-contact recidivists and contact recidivists for age or age at first sexual offence. A

significant difference was observed between the non-contact recidivists and contact recidivists with regard to age at first non-sexual offence (t=2.15, d.f.=20, p=.044) with contact recidivists being significantly younger than non-contact recidivists at first non-sexual offence.

Table 3. Distribution of total SVR 20 and total PCL: SV scores for non-contact recidivists and contact recidivists and comparison of significance using Mann-Whitney Analysis.

	Non-contact recidivists			**Contact recidivists**		
		n=20			n=20	
	Mean	SD	Range	Mean	SD	Range
SVR-20	9.40	6.03	1-26	20.45	7.47	4-30
PCL:SV	5.6	3.41	1-14	12.45	4.72	4-20
PCL:SV part 1	2.55	1.85	0-7	6.35	2.52	3-11
PCL:SV part 2	3.05	2.14	1-9	6.1	3.06	1-11

Table 3. shows the distribution of total SVR 20 and total PCL:SV scores for non-contact and contact sexual offenders and comparison of significance using Mann-Whitney Analysis. A significant difference was observed between the non-contact

recidivists and the contact recidivists with respect to total SVR-20 scores (U=54.0, n=40, p=.0000). A significant difference was found between the two groups on total PCL: SV scores (U=48.0, n=40, p=0.0000). Significant differences were also found between non-contact and contact recidivists on Part 1 and Part 2 of the PCL: SV (U=46.5, n=40, p=.0000 and U=84.5, n=40, p=.0013, respectively).

Table 4a and 4b. Individual PCL: SV Items for non-contact recidivists and contact recidivists and comparison of significance using Mann-Whitney Analysis.

Table 4a

PCL: SV Part 1 items	Results of Mann-Whitney Analysis	Group 1 mean	Group 2 mean
1. Superficial	**U=127.5, n=40, p=.0491***	0.25	0.75
2. Grandiose	**U=127.0, n=40, p=.0491***	0.15	0.65
3. Deceitful	**U=127.0, n=40, p=.0491***	0.10	0.60
4. Lacks remorse	**U=88.0, n=40, p=.0020****	0.60	1.40
5. Lacks empathy	**U=92.0, n=40, p=.0029****	0.60	1.40
6. Doesn't accept responsibility	**U=119.0, n=40, p=.0283***	0.95	1.55

N.B. results in bold indicate statistical significance

*at p<.05 level.
**at p<.01 level. Bonferroni correction applied to account for multiple comparisons. Result considered at more conservative level.

Table 4b

PCL: SV Part 2 items	Results of Mann-Whitney Analysis	Group 1 mean	Group 2 mean
7. Impulsive	U=171.5, n=40, p= n.s.	0.85	1.05
8. Poor behavioural controls	U=147.0, n=40, p= n.s.	0.30	0.75
9. Lacks goals	U=156.5, n=40, p= n.s.	0.55	0.85
10. Irresponsible	**U=108.5, n=40, p=.0122***	0.05	0.65
11. Adolescent antisocial behaviour	**U=91.0, n=40, p=.0026****	0.25	1.10
12. Adult antisocial behaviour	**U=80.0, n=40, p=.0008****	1.05	1.65

N.B. results in bold indicate statistical significance

*at p<.05 level.
**at p<.01 level. Bonferroni correction applied to account for multiple comparisons. Result considered at more conservative level.

Table 4. shows the significant differences observed between non-contact recidivists and contact recidivists on all Part 1 PCL: SV items. On Part 2 items, it was observed that contact recidivists were significantly more likely to be rated as Irresponsible (Item 10) (U=108.5, n=40, p=.0122); have had a history of Adolescent Antisocial Behaviour (Item 11) (U=91.0, n=40, p=.0026); and a history of Adult Antisocial Behaviour (Item 12) (U=80.0, n=40, p=.0008).

Table 5a, 5b and 5c. Comparison of SVR 20 items for non-contact recidivists and contact recidivists using a Mann-Whitney Analysis.

Table 5a

SVR-20 Items	Results of Mann-Whitney Analysis	Group 1 means	Group 2 means
A. Psychosocial Adjustment			
1. Sexual Deviation	**U=68, n=40, p=.0002****	0.85	1.85
2. Victim of Child Abuse	**U=98.5, n=40, p=.0051****	0.25	1.10
3. Psychopathy	**U=98.5, n=40, p=.0051****	0.05	0.70
4. Major Mental Illness	U=174.0, n=40, p= n.s.	0.45	0.20
5. Substance Abuse Problems	U=180.5, n=40, p= n.s.	0.65	0.45
6. Suicidal/Homicidal Ideation	U=171, n=40, p= n.s.	0.10	0.30

7. Relationship Problems	U=194.5, n=40, p= n.s.	1.30	1.25
8. Employment Problems	U=146.0, n=40, p= n.s.	0.70	1.10
9. Past Non-sexual Violent Offences	U=190.0, n=40, p= n.s.	1.25	1.30
10. Past Non-violent Offences	**U=120.0, n=40, p=.0304***	0.40	1.20
11. Past Supervision Failures	U=163.5, n=40, p= n.s.	0.70	1.05

N.B. results in bold indicate statistical significance

*at p<.05 level.
**at p<.01 level. Bonferroni correction applied to account for multiple comparisons. Result considered at more conservative level.

Table 5b

SVR-20 Items	Results of Mann-Whitney Analysis	Group 1 means	Group 2 means
B. Sexual Offences			
12. High Density Sexual Offences	U=176.0, n=40, p= n.s.	1.00	1.20
13. Multiple Sex Offence Type	**U=12.0, n=40, p=.0000****	0.15	1.60
14. Physical Harm to Victim	**U=90.0, n=40, p=.0024****	0.00	1.00
15. Uses Weapons or Threats of Death	U=130.0, n=40, p= n.s.	0.00	0.55
16. Escalation in Frequency or Severity	**U=1.5, n=40, p=.0000****	0.05	1.85
17. Extreme Minimisation or Denial	**U=126.0, n=40, p=.0460***	1.15	1.65

18. Attitudes that Support Sex Offences	**U=108.5, n=40, p=.0122***	0.25	0.85

N.B. results in bold indicate statistical significance

*at p<.05 level.
**at p<.01 level. Bonferroni correction applied to account for multiple comparisons. Result considered at more conservative level.

Table 5c

SVR-20 Items	**Results of Mann-Whitney Analysis**	**Group 1 means**	**Group 2 means**
C. Future Plans			
19. Lacks Realistic Plans	U=148.5, n=40, p= n.s.	0.75	0.75
20. Negative Attitude Towards Intervention	U=152.5, n=40, p= n.s.	0.25	0.85

N.B. results in bold indicate statistical significance

*at p<.05 level.
**at p<.01 level. Bonferroni correction applied to account for multiple comparisons. Result considered at more conservative level.

A comparison of SVR 20 items between non-contact recidivists and contact recidivists using a Mann-Whitney Analysis is illustrated in Table 5a, 5b, and 5c (above). Four items relating to Psychosocial Adjustment (Part A) were statistically

significant between the groups. These were Item 1. Sexual Deviation (U=68, n=40, p=.0002), Item 2. Victim of Child Abuse (U=98.5, n=40, p=.0051), Item 3. Psychopathy (U=98.5, n=40, p=.0051), and Item 10. Past Non-Violent Offences (U=120.0, n=40, p=.0304).

Table 5b shows that a number of statistically significant differences were observed between non-contact recidivists and contact recidivists on items relating to Part B: Sexual Offences. These include Multiple Sex Offence Type, Physical Harm to Victim, and Escalation in Frequency or Severity of Sex Offences. These results are a function of the division between the groups for research purposes. As such they are not clinically significant results.

A significant difference was observed between non-contact recidivists and contact recidivists on Extreme Minimisation or Denial (Item 17) (U=126.0, n=40, p=.0460) and Attitudes that Support or Condone Offending (Item 18) (U=108.5, n=40, p=.0122). Of note is the non-significant finding between the groups on Item 12. High Density Sexual Offences (U=176.0, n=40, p= n.s.).

No statistically significant differences were observed between non-contact recidivists and contact recidivists for the two SVR-20 items relating to Part C: Future Plans (Table 5c).

Table 6. Comparison of crossover for non-contact recidivists and contact recidivists using a Mann-Whitney Analysis.

Crossover	Results of Mann-Whitney Analysis	Group 1 means	Group 2 means
Age crossover	U=150.0, n=40, p= n.s.	1.35	1.60
Contact crossover	**U=10.0, n=40, p=.0000****	1.00	1.95
Sex crossover	U=140, n=40, p=n.s.	1.05	1.35
Victim crossover	U=160.0, n=40, p= n.s.	1.00	1.20
Homosexual	**U=120, n=40, p=.0304***	1.05	1.45
Association with other paedophiles	U=160.0, n=40, p= n.s.	1.00	1.20

N.B. results in bold indicate statistical significance

*at p<.05 level.
**at p<.01 level. Bonferroni correction applied to account for multiple comparisons. Result considered at more conservative level.

Table 6. shows statistically significant differences between non-contact recidivists and contact recidivists on homosexual offending (U=120, n=40, p=.0304). No

significant differences were observed between non-contact recidivists and contact recidivists for age or sex crossover. No significant differences were observed between non-contact recidivists and contact recidivists for association with other paedophiles. A statistically significant difference was observed for contact crossover (U=10.0, n=40, p=.0000). As noted above, this result was a function of the division between groups by sexual offence for analysis and is not considered clinically significant.

Table 7. Comparison of prior custodial sentence for non-contact recidivists and contact recidivists using a Mann-Whitney Analysis.

Criminal History	Result of Mann-Whitney	Group 1 mean	Group 2 mean
Prior custodial sentence	U=180.0, n=40, p= n.s.	1.15	1.25

N.B. results in bold indicate statistical significance

*at p<.05 level.
**at p<.01 level. Bonferroni correction applied to account for multiple comparisons. Result considered at more conservative level.

No significant difference was observed for offenders with regard to a prior custodial sentence, as illustrated in Table 7.

Table 8. Comparison of non-sexual convictions and offences for non-contact recidivists and contact recidivists using a *t* test.

Convictions and Offences	Results of *t* test	Group 1 mean	Group 2 mean
Total convictions	*t*=-1.38. d.f.=38, p=0.176	0.35	1.00
Total offences	*t*=-1.63, d.f.=38, p=0.112	0.85	2.10
Total convictions and offences	*t*=-1.57, d.f.= 38, p=0.126	1.20	3.10

Table 8. shows that no significant differences were observed for variables relating to number of non-sexual convictions and number of offences between non-contact recidivists and contact recidivists.

Table 9. History of psychosexual treatment

Psychosexual treatment	Chi-Square	Group 1 mean	Group 2 mean
	Chi-square=1.616, d.f.=1, n.s.	1.35	1.55

Seven non-contact recidivists (35 per cent) had a documented history of psychosexual treatment compared to over half (55 per cent) of the contact

recidivists. Table 9 shows the difference between the two groups with regard to treatment history was not significant (Chi-square=1.616, d.f.=1, n.s.).

Time at risk

This item referred to the amount of time elapsed from the date the subject was first at risk until the current assessment. This is the standard way of coding time at risk (Quinsey *et al.*, 1995). Non-contact recidivists were at risk for an average of 11 years 8 months (s.d. = 10 years 3 months) between first sexual offence and follow-up sexual offence. Contact recidivists were at risk for an average of 8 years 2 months (s.d. = 9 years 6 months). No significant difference was observed between non-contact recidivists and contact recidivists using a *t* test (t = 1.15, d.f. = 38, n.s.). No measure was available to determine the possible confound of time spent in prison during time at risk although there was no significant difference observed between non-contact recidivists and contact recidivists on prior history of custody.

Discussion

There is considerable responsibility on the clinician to identify sex offenders who may potentially commit more serious sexually violent behaviour (Hall, 1990) and an increased demand for evidence based risk assessments (Macpherson, 1997; Thomas-Peter and Warren, 1998). This research was aimed at assisting the clinician by determining the factors that differentiate between sexual offenders whose offending behaviour does not escalate in terms of offence severity, and those offenders who gravitate towards more serious sexual crimes.

Predicting which sexual offenders escalate in terms of offence severity is important for several reasons. First, non-contact offending has been found to be the most common type of sexual offence in the UK (Mair and Stevens, 1994; Snaith, 1983) although the non-contact and contact distinction between offenders has not been found to be associated with recidivism rates in a North American meta-analysis (Hanson and Bussiere, 1998). Second, although clinical opinion, and the few predictive research studies that have been undertaken among male non-contact sexual offenders, conclude that non-contact offenders do not generally gravitate towards more serious sexual crimes (Gebhard 1965; Mair, 1993; West 1987), several researchers have found that a significant numbers of non-contact offenders have a history of sexual violence involving physical contact (Sugarman *et al.* 1994; Walker and McCabe, 1973).

The attempt to place discrete typologies on sexual offenders has thus far eluded both clinicians and researchers. Overholser and Beck (1989) attempted to

differentiate a group of rapists and a group of sex offenders against children on the basis of social skills and attitudes towards sex and violence. They found that 25 per cent of rapists were mistakenly classified as child molesters. Segal and Marshall (1985) found limited group differences in a study of factors discriminating between sex offenders against children and rapists. In a sample of Scottish sex offenders, Mair (1993) found no difference in demographic and recidivism variables between rapists of adults or sex offenders against children. It is hoped that the simple dichotomous categorisation of sex offenders in the current study as non-contact recidivists and contact recidivists will receive support in future research.

Boer *et al.* (1997) suggested that the presence or absence of a certain number or combination of SVR-20 factors might be clinically useful in attempts to predict risk for different groups of sex offenders. The results of the present study show that a progressive pattern of sexual offending from non-contact sexual offending to contact sexual offending is associated with a combination of several factors.

Findings between non-contact recidivists and contact recidivists on the SVR-20 Part A: Psychosocial Adjustment.

Psychosocial Adjustment: *Sexual Deviation*

Sexual deviation was a significant factor discriminating the non-contact recidivists from the contact recidivists. The presence of a sexual deviation has been found to be one of the most significant factors predicting sexually violent recidivism in a range of research studies, reviews of the clinical literature, and

meta-analyses (Greer, 1991; Hanson and Bussiere, 1998; McGovern and Peters, 1988; Murphy *et al.*, 1992). This result is also consistent with studies on young sex offenders in North America and in Europe (Ross and Loss, 1991; Langstrom, 1999).

In the UK, a case file and criminal history review by Sugarman *et al.* (1994) over a follow-up period ranging between 8 and 25 years, found that non-contact sexual offenders who gravitated towards contact sexual offending were significantly more likely to have a history of excessive sexual drive. Chesterman and Sahota (1998) observed a self-reported high interest in sex, including deviant sexual interest, on questionnaire measures with mentally ill sex offenders admitted to a regional secure unit.

The importance of sexual deviation as a factor in risk assessment is illustrated by Rice and Harris, (1997) who found that sexual violence motivated primarily by a physiologically determined sexual deviation increased level of risk and was a significant predictor of sexually violent recidivism. The current study is based on the inference of a sexual deviation from self-report and clinical case notes rather than a phallometric measure of deviance. However, Boer *et al.* (1997a) indicate that an offender's history of sexual behaviour, whether inferred from self-report or behaviour, or through plethysmographic assessment of sexual arousal, is a risk factor for recidivism.

The stability and resistance to treatment is a second reason why sexual deviation is an important factor to consider. Clinical work with sex offenders has

established that self-reported sexual deviation is the primary reason for their offending and that sexual deviation remains a self-reported problem for years post-treatment. Hanson and Harris (1998) found that recidivist sexual offenders were more likely to be judged as sexually deviant than non-recidivists.

The identification of sexual deviation at an early age has important implications for reducing the risk of recidivism. In a review of the treatment literature, Hall (1993) found that the largest effect size for treatment efficacy on recidivism was for adolescent sexual offenders. Interventions during adolescence, before sexual offenders develop chronic patterns of offending, may have promise as an effective method of prevention.

The significant difference between non-contact sexual recidivists and contact sexual recidivists with regard to sexual deviation is unlikely to simply reflect a confound of the escalation towards more serious contact sexual offending. It has long been emphasised that the motives of power and anger predominately characterise rape, rather than a sexual assault primarily motivated by sexual deviation (Cohen *et al.* 1969; Knight and Prentky, 1990; Prentky *et al.* 1985). In a review of typologies of rapists, Blackburn (1993) concluded that

> **"rape is multi-dimensional, and that non-sexual as well as sexual goals need to be taken into account".** p 293

Similar results have been found by sociologists who do not view rape in terms of individual pathology. Scully and Marola (1985) found that anger, power, and

opportunity emerged as significant motivators towards rape in the view of 114 convicted rapists. Groth and colleagues further consider that rape reflects a 'pseudosexual act' which subordinates the role of sexual motivation in rape (Groth *et al.* 1979). It appears that the presence of a sexual deviation not only predicts sexual offence recidivism in general (Hanson and Bussiere, 1998) but, as this research demonstrates, sexual deviation is a powerful discriminatory factor between sex offenders who escalate in terms of offence severity and sex offenders who recidivate with non-contact sexual offending.

Psychosocial Adjustment: ***Childhood Victimisation***

Childhood victimisation was found to be a significant factor discriminating between non-contact sex offenders and contact sex offenders in the current research. The relevance of a history of sexual abuse in childhood has produced mixed results in the existing literature. The finding is consistent with the literature for recidivism rates of sex offenders in general. McGovern and Peters (1988) considered a history of child victimisation to be relevant in the assessment of sex offenders. Childhood victimisation is a general risk factor for criminality and violence and predicts sexual violence in adulthood (Hanson and Bussiere, 1996).

Reviews of the literature conclude that a history of child abuse is linked to sex offending possibly because of the influence of sexual abuse on deviant sexual practices (Marshall *et al.* 1990). Hanson and Harris (1998) found that recidivists were more likely to have histories of sexual and emotional abuse, with 27 per cent of recidivists having been taken into the care of child protective services compared to 15 per cent of the non-recidivists. The relevance of sexual abuse is

also consistent with studies on risk of recidivism in young sex offenders (Ross and Loss, 1991). In an UK, study Manocha and Mezey (1998) found that almost one-third of adolescent sex offenders reported a prior history of abuse. Lewin *et al.* (1994) found a definite history of physical and sexual abuse in 48 per cent of offenders referred to a community based treatment programme. In a review of the professional literature, Jehu (1991) concluded that there was an association between sexual offending in adulthood and a history of sexual abuse in childhood. There continues to remain debate in the literature as to the importance of a history of child abuse on sex offending as an adult. Sugarman *et al.* (1994) failed to find an association between more serious sexual recidivism and a history of abuse or neglect. The meta-analysis conducted by Hanson and Bussiere (1998) found no specific link between sexually violent recidivism and a history of child sexual abuse. Socio-psychological theories suggest that child abuse is a causal factor (Marshall *et al.* 1990) while bio-psychological theories view an abuse history as a risk marker (Boer *et al.* 1997a).

The reason for the significant discriminative ability between non-contact sexual recidivists and contact sexual recidivists on childhood abuse is not entirely clear. It may be that the majority of non-contact recidivists do not gravitate towards contact sexual offending due to the absence of exposure to an *abusive orientation* in childhood. Bentovim (1996) considered that abuse in childhood is an important factor in triggering abusive action as an adult. He considers that that an early experience of abuse is the key factor leading to abusive behaviour towards children in adulthood. The descriptive account provided by Manocha and Mezey (1998) also speculates on interplay between sexual abuse in childhood and other

predisposing factors that may result in the abuse of children as an adult.

At present the SVR-20 guidelines for coding childhood victimisation refer to physical non-sexual and sexual abuse as one item. One potential area that may require further explanation is the type of victimisation and the effect on offending in general and sexual offending in particular. It is possible that sexual abuse in childhood may produce behaviours in adulthood that differ from those associated with physical abuse or serious neglect in childhood. An optimal study would follow the behaviour of a cohort of male children who have and have not been sexually abused, into adulthood. This is an important consideration as sexual abuse in childhood is not a rarity. The increased vulnerability to rape and sexual assault in adulthood among previously abused women is well documented. Runtz and Briere (1988) found that 52 per cent of women attending a crisis-counselling centre, who had been sexually abused in childhood, were sexually assaulted as adults. This compared to 14 per cent of the non-abused women. In a random sample of women, Russell, (1982) found that 63 per cent of women sexually victimised before the age of 14 suffered a serious sexual assault after that age in comparison to 35 per cent who had no history of sexual abuse in childhood.

Psychosocial Adjustment: ***Major Mental Illness***

The presence of a serious cognitive or intellectual impairment, psychotic condition or significant mood disorder, or suicidal ideation, was not found to significantly discriminate between non-contact recidivists and contact recidivists. Suicidal and homicidal ideation, and stated intention to harm self or others are acknowledged by the authors of the SVR-20 to have the weakest empirical

support as a risk factor for assessments of sex offenders (Boer *et al.* 1997).

Considering the presence of mental illness and suicidal ideation first, the non-significant finding may be due to the low rate of major mood disorder amongst the sexual offenders in the current research. Previous research has found an association between negative emotional states and the commission of sex offences (Proulx *et al.* 1997) although the meta-analyses of Hanson and Bussiere (1998) found that psychological maladjustment had little or no relationship with sexual offence recidivism in general.

Murray *et al.* (1992) found that paedophilic behaviour was almost non-existent in a mentally ill (defined as psychosis) group of sex offenders. Sahota and Chesterman (1997) found few studies relating to the mentally ill sex offender and clinician opinion suggests that the mentally ill are responsible for only a small proportion of sexual offences (Chiswick, 1983; Grubin and Gunn, 1991). It may be that subjective distress is a transient state and that significant mood disorders can only readily be assessed at time of the offence. A further view suggests that within subject correlations between mood state and recidivism may be a risk variable significant in general, rather than between sexual offender groups.

Learning difficulty is considered a major mental illness by the SVR-20 and is a risk factor in the literature for offending in general (Hodgins, 1992), with learning disabled men three times more likely to commit a general offence and five times more likely to commit a violent offence than men without a diagnosis of learning difficulty. The relationship between learning disability and sex offending was not

examined by Hodgins. The review of personality disordered, mentally ill and mentally handicapped sex offenders by Murray *et al.* (1992) found that paedophilic behaviour was most commonly in the mentally handicapped group. Mentally handicapped offenders had recorded sex offences at an earlier age and committed less offences of penile penetration of the vagina. Rice *et al.* (1990) found that a diagnosis of 'mental retardation' was a predictor of recidivism on release. Learning difficulty was not a significant factor in the current research. This may reflect the low numbers of mentally disordered offenders in the study.

The overall opinion expressed in the literature, combined with the clinical experience gained using the SVR-20, suggests that the item 'Major Mental Illness' might more usefully be split into mental disorder and mental handicap given the different prevalence rates, victim selection, and offence type, reported in the literature as associated with mentally ill and mentally handicapped populations of sex offenders.

Psychosocial Adjustment: *Substance Abuse Problems*

There was no significant difference between non-contact recidivists and contact recidivists with regard to substance use. Existing clinical and research evidence has highlighted the misuse of alcohol or illicit and non-prescribed drugs as associated with an increased risk for sexual offending (McGovern and Peters, 1988; Quinsey, *et al.* 1995). Boer *et al.* (1997b) also noted that some offenders use substances to disinhibit themselves when they are considering sexual violence. Chesterman and Sahota (1998) found that 60 per cent of their sample of mentally ill sex offenders reported alcohol and substance abuse at the time of the

index offence. Overholser and Beck (1989) highlighted the significant role that alcohol played in impairing the offender's ability to voluntarily suppress sexual arousal.

The current result is consistent with the case file review of Sugarman *et al.* (1994) who found that a history of alcohol or other substance abuse was not associated with a progression towards contact sexual offending. Hanson and Bussiere (1998) also found no evidence to suggest that alcohol was a risk factor for sexual offence recidivism. The current research suggests that alcohol plays a limited role in the progression from non-contact offending to contact sexual offending.

Psychosocial Adjustment: *Relationship Problems*

Non-contact recidivists and contact recidivists did not significantly differ with regard to current relationship status. Relationship status has been found to be related to recidivism with offenders in general (Rice *et al.* 1990) and is considered important in the evaluation of adult sex offenders (Greer, 1991; McGovern and Peters, 1988; Murphy *et al.* 1992) and adolescent sex offenders (Ross and Loss; 1991). In the current study, relationship status did not prove a significant predictor variable between non-contact recidivists and contact recidivists. This result is consistent with the data available from Lewin *et al.* (1994), who found that the majority of sex offenders attending for community treatment to be single. The current result may be a function of the small size of the current sample or the significant number of males in both recidivist groups who were single in

comparison to the small number of offenders in a relationship or married at the time of data collection.

Psychosocial Adjustment: *Employment problems*

The failure to achieve or maintain employment approached remained a modest although not statistically significant factor discriminating between non-contact and contact recidivists. Sugarman *et al.* (1994) also failed to find a significant difference in employment history for exhibitionists who gravitated towards contact offending over a follow-up period ranging between 8 and 25 years. The general literature on sexual offence recidivism highlights employment problems as a risk marker that predicts sexual violence (Boer *et al.* 1997b). Also clinical reviews have suggested that employment problems can lead to short term distress which sometimes lead to short term increases sexually deviant thoughts and urges (Proulx *et al.* 1997). Relationship problems appear to be only modestly associated with a progression from non-contact offending towards contact sexual offending.

Psychosocial Adjustment: *Previous Offending*

A significant finding was the difference in levels of non-violent offending between non-contact recidivists and contact recidivists in the current study as assessed using the SVR-20 item criteria. The same result was not observed using a mean total of offences and convictions between non-contact offenders and contact offenders and may be a feature of the less strict criteria used to define this item on the SVR-20. To illustrate, Past Non-violent Offences on the SVR-20 includes possible or partial evidence of criminal conduct not necessarily amounting to a criminal conviction. The item also allows the consideration of non-violent conduct

that occurs in a psychiatric hospital or prison. Thus the mean total of offending behaviours is not calculated on convictions alone. The SVR-20 item may be a more pure measure of offending although a less sensitive measure of the true rates of non-violent offending resulting in criminal conviction. A significant difference in non-sexual violent offending was not observed.

There is general agreement in the literature that sex offending is associated with general criminal non-violent offending. Home Office (Home Office, 1995) estimates of offending of a 1953 birth cohort suggest that over 40 per cent of sex offenders start their criminal career with an offence other than a sexual offence. The current study found that 50 per cent of non-contact offenders had a history of convictions and offences compared to 60 per cent of the contact recidivists.

This result is similar to that obtained in the descriptive study of sex offenders attending a community treatment programme, Lewin *et al.* (1994) found that 52 per cent had a previous history of sex offences and 70 per cent had a previous history of non-sexual offences. Canter and Kirby (1995) found that 44 per cent of a group of 416 sex offenders against children had previous criminal convictions and Sugarman *et al.* (1994) found that 75 per cent of their sample of 117 non-contact sexual offenders had a conviction for at least one other offence other than a non-contact sexual offence.

The significant difference between non-contact recidivists and contact-recidivists on non-violent offending as assessed on the SVR-20 factor has support in the review by Sugarman *et al.* (1994) who found that exhibitionists who gravitated

towards contact offending were significantly more likely to have a history of convictions for acquisitive offending.

The results tentatively suggest that more serious forms of sex offending and violent offending are not closely associated. This contention receives some support in the literature. Chesterman and Sahota (1998) observed that three quarters of mentally ill sex offenders admitted to a regional secure unit had a previous non-sexual violent conviction, although the retrospective analysis conducted by Quinsey *et al.* (1995) did not find a significant relationship between sex offending and violent offending. Quinsey and colleagues identified 13 variables associated with recidivism in violent offenders and attempted to similarly classify recidivism rates with sex offenders. Further analysis on the predictive properties of the scale led the authors to recommend abandoning the scale as a measure of sex offence recidivism (Rice and Harris, 1995).

Psychosocial Adjustment: ***Past Supervision Failures***

A difference in the rate of violation of the conditions of release or community supervision was not found to discriminate between non-contact recidivists and contact recidivists. The current result may be explained by two reasons. First, a low rate of community violations was observed in the current study. Second, community violations may be associated with criminality and violence in general rather than sex offending in particular. In a study to determine the recidivism rates of prisoners released from a Canadian federal prison, Bonta *et al.* (1996) found that individuals who had violated the conditions of release or community supervision were at increased risk for criminality and violence. Although professional reviews consider supervision failure to be an important factor to

consider in evaluating level of risk with offenders in general (McGovern and Peters, 1988) it may be that this factor does not apply to sex offenders.

Findings between non-contact recidivists and contact recidivists on the SVR-20 Part B: Sexual offending

A number of statistically significant differences were observed between the non-contact recidivists and the contact recidivists on items of the SVR-20 relating to Sexual Offences. These results are considered a function of the study groups and reflect the differences between the groups with regard to contact and non-contact offending. They may not be open to interpretation due to the risk of circularity. As such they are not clinically meaningful results.

Sexual Offending: *High Density Sexual Offences*

Of note however, was the non-significant finding between the groups on Item 12 of the SVR-20: High Density Sexual Offences. A tentative conclusion from the current research is that the non-contact recidivists and contact recidivists in the study committed a similar frequency of offences taking into account time at risk. The offences varied only with respect to offence severity and escalation from non-contact to contact offending. This result runs contrary to the sample of offenders studied by Mair and Stevens (1994). They found that exhibitionists have a relatively high rate of sexual recidivism and higher prevalence of sexual convictions both before the index offence and over the ten-year follow-up period. The current finding is consistent with the meta-analysis of Hanson and Bussiere (1998) who failed to find a difference between non-contact and contact offenders

and recidivism rates in a North American population of sex offenders.

No statistically significant differences were observed between non-contact recidivists and contact recidivists for the two SVR-20 items relating to a lack of realistic plans and negative attitude towards intervention. A lack of realistic plans appears to have limited support in the literature as a factor associated with sex offending in general. Proulx *et al.* (1997) has suggested that a lack of realistic plans may lead to short term distress which may increase the likelihood and frequency of sexual offending. This factor is also discussed in the professional reviews as having predictive utility with juvenile sex offenders (Ross and Loss, 1991). It may be that the transient nature of realistic plans can only readily be assessed at time of interview.

A second view might be the dynamics of the assessment. As the majority of offenders were initially referred in connection with Court proceedings, offender's plans were dependent to some extent on the outcome of their Court appearance. This might equally apply to judgements made on attitude towards intervention. Clinical experience suggests that some sex offenders readily agree to participate in treatment pre-sentencing although the motivation to attend diminishes post-conviction. This contention has support in the meta-analysis of Hanson and Bussiere (1998). They who found that offenders who failed to complete treatment were at increased risk for both sexual and general recidivism, and that sex offenders who expressed a low motivation for treatment were not at significantly increased risk of recidivism. The SVR-20 item relating to a negative attitude towards intervention might have greater validity if the item concerned previous

treatment dropout in particular rather than attitude towards intervention in general.

Findings between non-contact recidivists and contact recidivists on the Psychopathy Checklist: Screening Version.

The results of the current study suggests that non-contact sexual recidivists can be discriminated from contact sexual recidivists on the basis of total ratings on the Psychopathy Checklist: Screening Version (Hart *et al.* 1995) although the following findings are limited by the lack of statistical significance between raters for the PCL: SV Total and Factor scores. Belfrage (1998) found that a Kendall's τ of 0.6 or above to be consistent with a high inter-rater reliability. Hart et al. (1994) found an inter-rater reliability of 0.61 during the development of the PCL: SV. Inter-rater agreement on Kendall's τ of above 0.6 was achieved for the PCL: SV in the current study although statistical significance was not achieved. A greater number of inter-rater ratings may have to be made in future studies.

On Part 1 of the PCL: SV, the interpersonal personality traits of grandiosity and manipulativeness, and affective traits of lack of empathy and lack of remorse, were significantly different between the non-contact recidivists and contact recidivists. Significant though modest difference was observed between the non-contact recidivists and contact recidivists on the traits of superficiality and failure to accept responsibility for actions.

Significant differences were also found between non-contact and contact recidivists on Part 1 and Part 2 of the PCL: SV, with the strongest difference between groups emerging on interpersonal and affective factors. This is an interesting result as the literature review of Miller and Eisenberg (1988) suggested that empathy, guilt, and other affective characteristics, were inversely related to antisocial behaviours. Hemphill *et al,* (1998) highlighted the importance of interpersonal and affective characteristics as assessed by PCL-R Factor for violence prediction. Prentky (1995) has also noted that a general lack of emotional concern and empathic relatedness are powerful disinhibitors for interpersonal violence and are common foci for treatment targets with sex offenders. It may be that the findings of the current research highlight the importance of developing victim empathy and emotional relatedness to inhibit the potential for contact sexual recidivism amongst non-contact sexual offenders.

An observation was that none of the non-contact recidivists met the diagnostic cut-off for psychopathy on the PCL: SV while two contact sexual offenders met cut-off criteria for psychopathy on the PCL: SV and were subsequently confirmed as psychopathic on the PCL-R (Hare, 1991). It is of interest to note that only five per cent of the albeit small sample of recidivist sexual offenders in the current research were diagnosed as psychopaths. While this result is not consistent with North American research on prevalence of psychopaths in sex offender populations, Cooke (1994) obtained ratings on a sample of prisoners and found three per cent of the adult male prisoner population within Scotland met the PCL-R criterion for psychopathy. Even with a revised cut-off score established using

Item Response Theory (IRT), Cooke and Michie (1997) found that eight per cent of the Scottish prisoners met diagnostic criteria for psychopathy.

A significant difference was observed between non-contact recidivists and contact recidivists on the Adolescent Antisocial Behaviour and Adult Antisocial Behaviour items of the PCL: SV. A case file and criminal history review by Sugarman *et al.* (1994) found that exhibitionists whose offending behaviour escalated in severity were significantly more likely to have a history of childhood conduct disorder. Further evidence for an earlier onset to antisocial behaviour comes from the significant difference in age at first offence between non-contact recidivists and contact recidivists found in the current study. The current research established that contact recidivists begin their non-sexual offending career at an earlier age than non-contact recidivists although this observation did not hold between non-contact recidivists and contact recidivists with regard to age at first sexual offence.

Several points can be concluded from the significant difference observed between non-contact recidivists and contact recidivists with regard to characteristics of psychopathy as assessed by the PCL: SV in the current research. First, when the PCL: SV is used as a dimensional measures as supported in the PCL: SV manual (Hart *et al.* 1995), the presence of a number of characteristics consistent with criteria for psychopathy, in particular affective and interpersonal characteristics, has a significant effect on the severity of sexual offence recidivism, and appears to have a significant discriminative ability between non-contact sexual offenders and contact sexual offenders. Second, a tentative conclusion might be that the presence

of moderate levels of psychopathic characteristics as assessed using the PCL: SV is a risk factor for escalation from non-contact sexual offending to contact sexual offending. This view is consistent with the view expressed in the PCL: SV manual (Hart *et al.* 1995) that

"psychopathic *traits* may prove useful for research in predicting behaviour where no one fulfils the diagnostic criteria for psychopathy" p. 33

The literature on sex offenders in general suggests that motives of power and anger predominately characterise the contact sexual offence of rape (Cohen *et al.* 1969; Knight and Prentky, 1990; Prentky *et al.* 1995). It is interesting therefore to note that, with the exception of the SVR-20, none of the existing assessment guidelines incorporate a measure of psychopathy to as a variable to assess for risk of sexual violence (Greer, 1991; McGovern and Peters, 1988; Murphy *et al.* 1992; Ross and Loss; 1991) despite unanimous agreement on the importance of psychopathy in the assessment of violence in general (Webster *et al.* 1994; Webster *et al.* 1995).

Quinsey, *et al.* (1995) found that psychopathy functioned as a general predictor of sexual and violent recidivism. Psychopathy was clearly distinct from sexual deviance and predicted sexual and violent recidivism among sex offenders in the same way and to the same degree that it predicted sexual and violent recidivism among a general sample of mentally disordered offenders. The present research confirms the validity of psychopathic *traits* as important indicators to consider

when assessing the likelihood of a non-contact offender recidivating in a more sexually violent manner.

Findings between non-contact recidivists and contact recidivists on victim type, crossover, time at risk, history of prior custodial sentence, and psychosexual treatment.

Victim Type

Reviews of follow-up studies of sex offenders typically find that the rate of sexual recidivism is higher for sex offenders who had offended against a male victim. A statistically significant difference was found between non-contact recidivists and contact recidivists with regard to victim selection on victim-sex crossover. This may have reflected the higher number of homosexual offences in the contact group although the result is consist with the literature on the effect of male child victim selection on recidivism rates of sex offenders in general (Hanson and Bussiere, 1998).

The current research found that non-contact recidivists and contact recidivists who had sexually offended against a male child at first or follow-up offence were more likely to report a personal history of childhood abuse. This is consistent with the literature. Jehu (1991) found an association between child sexual abuse and later homosexuality and Finkelhor (1984) found that men who had been sexually abused as children by other men were more than four times more likely to be currently engaged in homosexual activity than those who had not been abused.

Finkelhor (1986) has speculated that males abused as children by other males go on to repeat their offences driven by a need to master the helplessness and hurt associated with their own victimisation by re-enacting similar encounters while in a position of power. It is difficult to establish why contact sexual recidivists were more likely to commit a sexual offence against a male child. It may be that a causal link exists whereby boys who have been abused by an older male may label themselves inappropriately as homosexual. It might also be the case that some boys might experience homosexual curiosity at an early age that may make them vulnerable to exploitation by older predatory homosexual males.

The apparent discriminative power of homosexual victim selection between non-contact recidivists and contact recidivists in the current study contrasts with the failure of attempts to place discrete typologies on sexual offenders (Mair, 1993; Overholser and Beck, 1989; Segal and Marshall, 1985). Victim-offender relationship and victim age crossover showed no significant ability to discriminate between non-contact recidivists and contact recidivists in the current study and is largely consistent with the findings of the above researchers. It may be that a simple classification of sex offenders as homosexual or heterosexual by victim selection in the current research will receive support in future research on predictions of sexual offence escalation with non-contact offenders.

Time Elapsed since First Offence

The length of time elapsed from the date an offender committed a non-contact sexual offence until they recidivate with a non-contact sexual offence or contact

sexual offence was not found to be significant between the two groups. Time elapsed from the date of first offence until current assessment is the standard way of coding time at risk (Quinsey *et al.* 1995). This was an unexpected although important finding according to clinical experience. The result makes the comparisons between non-contact and contact recidivists more meaningful than a significant difference in time elapsed between offences, as both groups had equal time to recidivate. No difference was found between groups on age although the mean age of the sex offenders in the current study was younger than the of sex offenders described in the sample of Lewin *et al.* (1994). Non-contact recidivists were at risk for an average of 11 years 8 months with a standard deviation of 10 years 3 months between first sexual offence and follow-up sexual offence. Contact recidivists were at risk for an average of 8 years 2 months with a standard deviation of 9 years 6 months. Time at risk ranged from less than one year to over 21 years. A measure to determine months at risk and the confound of time spent in prison during time at risk was not available although there was no difference in history of prior custodial sentences between the non-contact and contact offenders. The overall finding is consistent with the other UK samples of sex offenders and with the North American literature which suggests that sexual offending occurs over a long-periods (Abel, 1988).

Prior History of a Custodial Sentence

Prior history of a custodial sentence was examined between non-contact recidivists and contact recidivists. No significant difference was observed between groups on this measure. Custody has the short-term benefit of public protection and deterrence. However, a number of studies have found that recidivism rates are

higher where a sex offender has been imprisoned as compared to community treatment groups.

Psychosexual Treatment

The tentative conclusion from the current research was that psychosexual treatment had no effect on reducing the escalation from non-contact sexual offending to contact sexual offending. The ability to effectively reduce sexual offending is of critical importance to society and influential to decisions made in the criminal justice system. The current study found that over half of those non-contact recidivists who received psychosexual treatment progressed from non-contact sexual offending towards more serious sexually violent recidivism. Over one third of non-contact offenders with a treatment history subsequently recidivated with a further non-contact offence. The difference in numbers of offenders receiving treatment between the two groups was not statistically significant. It is notable that only an established history of psychosexual treatment was coded in the current study. Previous treatment for substance or alcohol abuse, anger or social skill training, was not included although a number of non-contact and contact recidivists had a documented treatment history for these problems. A possible explanation for the greater number of sex offenders in the contact group receiving clinical intervention may be an awareness by the clinician of an elevated level of risk of recidivism at the offenders first assessment.

Although the limited effects of psychosexual treatment make rather depressing reading, they are consistent with North American studies on recidivism rates of sexual offenders receiving psychosexual treatment. Furby *et al.* (1989) conducted

a meta-analysis of recidivism rates of North American sex offenders who received clinical treatment. They found no evidence that psychosexual treatment was differentially effective for different types of offenders. This study was criticised for taking a "methodologically ideal" approach towards assessing recidivism following treatment (Marshall *et al.* 1991). Hanson and Harris (1998) found that clinical treatment had no effect on recidivism rates. In their study of 136 extra-familial child molesters in a six year follow up, Rice *et al.* (1991) found that behavioural treatment did not effect recidivism rates. The meta-analysis of Hanson and Bussiere (1998) found that recidivist sex offenders were more likely to have dropped out or otherwise been considered a treatment failure. The extent of non-compliance with previous remediation attempts was not coded in this study and may be an area for future investigation. One study found that recidivism for homosexual offenders against boys increased as a result of treatment (Sturgeon and Taylor, 1980). Quinsey *et al.* (1993) have argued that the existing literature does not support the conclusion that comprehensive cognitive behavioural programmes and combined psychological and hormonal treatment are effective in reducing the rate of recidivism with sex offenders.

Becker and Hunter (1992) found reasons to be confident regarding sex offender treatment. In a review of the literature on single case studies, smaller scale sex offender treatment programmes, and large scale treatment programmes, they suggested that treatment outcome may be a function of type of sex offence, with sex offenders against children having the most significant response to treatment. Marshal and Barbaree (1988) showed that the recidivism rates for treated offenders was 25 per cent while the untreated group had a recidivism rate of 40 per cent.

Marshall *et al.* (1991) have suggested that

> **"At the moment, there is insufficient data to identify in advance those patients who would profit least (except of course for rapists), and this topic urgently needs research. However, such research should be directed at identifying what it is current programmes are missing rather than identifying who should or should not be treated"** (p. 681).

Quinsey *et al.* (1993) have argued that the approach taken in the review by Marshall *et al.* is unable to provide scientifically satisfactory answers to questions concerning treatment efficacy. They suggest a meta-analytic approach to the factors considered as efficacious in treatment and random design outcome research. In response, Marshall (1993) countered that the evidence to date is encouraging and that the proposals of Quinsey *et al.* (1993) will discourage efforts to publish outcome data. It may be that any reduction in sexual recidivism is significant in terms of harm to the victims and costs to society.

The tentative conclusion from the current research was that psychosexual treatment had no effect on reducing the severity of sexual offence recidivism. Taken in context however, it may be premature from the small sample size to suggest that clinical treatment for sex offenders has no appreciable effect on recidivism rates overall.

Methodological considerations

The most scientifically valid way to conduct this research would have been a long-term follow up of a large sample of non-contact sex offenders and contact sex offenders who are released into the community after being evaluated with the SVR-20 and PCL: SV. The problem is that base rates of officially detected sexually violent recidivism are low (Rice and Harris, 1995). The follow-back or retrospective-prospective comparison study of offenders has been successfully employed by Quinsey and others (1997) and Hanson and Harris (1998). The advantage of the design of the current study is that it is less complex and expensive to conduct, and the base rate of recidivism is optimal at 100 per cent.

In the current study, cases were selected on the basis that type of recidivism was known with certainty. The SVR-20 was coded without the author being blind to the outcome of the case. The inter-rater agreement achieved for Part A and Part B of the SVR-20 was one method of ensuring that outcome did not significantly effect the results obtained on the measure. Poor inter-rater reliability was achieved for Part C: 'Future Plans' and this may reflect the requirement for assessments to be made prior to sentencing, where outcome is not yet known. Statistically significant agreement between raters was not achieved for PCL: SV Total or Factor ratings. The lack of statistical significance for the PCL: SV Total and Factor scores may reflect the small number of cases despite a Kendall's τ of 0.6 or above and this finding may require to be replicated with a larger sample.

A further methodological issue concerns the sample in the current research. First, significant findings established with a small sample size may not be sufficient to generalise to a wider population of sex offenders despite the use of non-parametric statistical tests which take small sample size into consideration (Bryman and Cramer, 1999). Second, the sample was not a randomly selected sample of sex offenders. A large number of cases were excluded at the data gathering stage due to a lack of sufficient collateral material. Third, it may be that more deviant or highly recidivist sexual offenders are not referred to the Douglas Inch Centre for assessment as this had been completed previously or the Court did not consider any benefit in obtaining an opinion prior to sentencing. These methodological weaknesses can only be overcome by a long-term follow up of a large sample of sex offenders released into the community and this was not a feasible option in the current research or a reasonable option for society in general.

Outcome of Hypotheses

Hypothesis 1.

Contact recidivists will exhibit significantly higher levels of sexual deviation than non-contact recidivists. Hypothesis 1 was supported.

Hypothesis 2.

Contact recidivists will exhibit significantly higher levels of childhood victimisation than non-contact recidivists. Hypothesis 2 was supported.

Hypothesis 3.

Contact recidivists will exhibit significantly higher levels of psychopathy than non-contact recidivists. Hypothesis 3 was supported.

Hypothesis 4.

Contact recidivists will exhibit significantly higher levels of major mental illness than non-contact recidivists. Hypothesis 4 was not supported.

Hypothesis 5.

Contact recidivists will exhibit significantly higher levels of non-sexual violent offending than non-contact recidivists. Hypothesis 5 was not supported.

Hypothesis 6.

Contact recidivists will exhibit significantly higher levels of general non-violent offending than non-contact recidivists. Hypothesis 6 was supported.

Hypothesis 7.

Contact recidivists will have committed significantly more homosexual offences than non-contact recidivists. Hypothesis 7 was supported.

Hypothesis 8.

Contact recidivists will be significantly younger at age of first offence than non-contact recidivists. Hypothesis 8 was supported.

Hypothesis 9.

Contact recidivists will have had significantly more associations with other sex offenders than non-contact recidivists. Hypothesis 9 was not supported.

Hypothesis 10.

Contact recidivists will have had significantly higher levels of sex offence crossover than non-contact recidivists. Hypothesis 10 was not supported.

Conclusions

Consistent with Monahan and Steadman's (1994) theory of violent behaviour, past sexual offending is predictive of future sexual offending in general (Hall, 1990). Grubin and Wingate (1996) comment on the importance of accurate risk assessments unless all offenders are incarcerated for indeterminate lengths of time. Thomas-Peter and Warren (1998) note that psychologists have no statutory responsibility enshrined in legislation. This does not mean that psychologists do not have responsibilities or that their responsibilities should not be extended.

Psychologists are frequently called upon to make a judgement about the level of risk posed by an individual (Macpherson, 1997) and it is of considerable importance to the clinician to establish a valid and reliable process for discriminating between sex offenders who recidivate with increased offence severity from those who remain at risk of non contact sex offending. Psychologists are responsible for what they do and what they fail to do. There is

clearly a need for more evidence-based risk assessments and continued psychological research on risk factors to improve accuracy of prediction.

Furby (1998) has commented that any study dealing with risk assessment and recidivism of sex offenders faces almost incapacitating limitations. However, such assessments continue to be required to assist in sentencing or to determine whether a custodial sentence would be appropriate given the needs and rights of the offender and those of the public. Inaccurate assessment could result in the person being unnecessary detained or deprived of their liberty or members of the public being placed at risk. Although the results of the study are preliminary and will need further exploration using a larger sample, it is crucial that psychologists have the appropriate methods to conduct risk assessment. It was apparent that several clear differences exist between non-contact and contact recidivists on psychosocial history, personality measures, criminogenic variables, and victim selection. These differences should be of utility in predicting the severity of recidivist sex offending with non-contact sexual offenders.

A further benefit of the current findings may supported by the research of Hall (1995) who observed that treatment was more effective with outpatients than with institutionalised sexual offenders. Effective treatment might have promise with sexual offenders who are not apprehended by the legal system. It follows that effective treatment directed towards the most common forms of sexual offending may indeed be a better deterrent of sexual offence recidivism than those treatments that are restricted to legally apprehended sexual offenders who may constitute a minority of all sexual aggressors.

It is important to note those factors that discriminated between non-contact recidivists and contact recidivists were primarily historical in nature, reflecting fixed or relatively stable characteristics. In the absence of consensus on sex offender treatment, risk management of sexual offenders in the community will have to be improved. The current research has attempted to provide the clinician with assessment procedures that are useful in practice, as failure to accurately predict the severity of sexual offending has human and financial costs. The current study offers the potential for early detection of a potentially more serious escalation in sexual offending to allow for the possibility of supervision and clinical risk management.

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Appendix

Coding Sheet

Case Number:

Demographic

age	
Currently single = 1	
Currently in relationship = 2	
Currently married = 3	

Criminal history

Date of first offence	
Age at first offence	
Prior custodial sentence **No = 0 Yes = 1**	
Non-sexual crimes of violence or implied violence against person No = 0 Yes = 1	
Major violence (murder, attempt murder, culpable homicide, serious assault)	
Minor violence (assault, threatening behaviour, possession of offensive weapon)	
Violent acquisition (robbery & assault with intent to rob)	
Crimes of dishonesty No = 0 Yes = 1	
Housebreaking or opening lockfast places	
Other categories (shoplifting, reset, fraud)	
Fire-raising, malicious or reckless conduct No = 0 Yes = 1	
Other crimes No = 0 Yes = 1	
Crimes against public justice (contempt of Court, resisting arrest, bail offences).	
Crimes involving drugs	
Other categories	
Miscellaneous offences No = 0 Yes = 1	
Offences relating to motor vehicles No = 0 Yes = 1	
Drunk driving	
Other driving (reckless or careless driving)	

Total number of **convictions**	
Total number of **offences**	
Total convictions and **offences**	

Sex Offence History

Date of first recorded sex offence	
Age at first recorded sex offence	
Type and number of first recorded sex offence(s) Breach of the peace Obscene telephone calls Indecent exposure Indecent assault Lewd and libidinous practices and behaviour Unlawful sexual intercourse with a girl under 16 Assault Homosexual acts Rape	
non-contact (act involving no physical contact) **No = 0 Yes = 1**	
contact (involving physical contact) **No = 0 Yes = 1**	
number of victims =	
female victim relation = 1 female victim stranger = 2	
female child victim relation =1 female child victim stranger =2	
male victim relation =1 male victim stranger =2	
male child victim relation =1 male child victim stranger =2	

Time between first and follow-up sexual offence =	

Intervening sex offences

Type and number of sex offence(s) Breach of the peace Obscene telephone calls Indecent exposure Indecent assault Lewd and libidinous practices and behaviour Unlawful sexual intercourse with a girl under 16 Assault Homosexual acts Rape	
non-contact (act involving no physical contact **No = 0 Yes = 1**	
contact (involving physical contact) **No = 0 Yes = 1**	

Recent Offence

Type and number of offence(s) at follow-up	
Breach of the peace Obscene telephone calls Indecent exposure Indecent assault Lewd and libidinous practices and behaviour Unlawful sexual intercourse with a girl under 16 Assault Homosexual acts Rape	
non-contact (act involving no physical contact) **No = 0 Yes = 1**	
contact (involving physical contact) **No = 0 Yes = 1**	
number of victims =	
female victim relation = 1 female victim stranger =2	
female child victim relation =1 female child victim stranger =2	
male victim relation =1 male victim stranger =2	
male child victim relation =1 male child victim stranger =2	

PCL-SV

Part 1

Item 1: Superficial • Presentation is shallow and difficult to believe • Displays of emotion do not appear genuine • Attempts to portray self in good light • Tells unlikely stories • Alters statements when challenged with facts or inconsistencies • Uses technical language and jargon, often inappropriately • Conversation and interpersonal behaviour are engaging	*0 1 2 Omit*
Item 2: Grandiose • View of abilities and self-worth is inflated • Self-assured and opinionated • Exaggerates status and reputation • Considers circumstances to be a result of bad luck • Sees self as victim of the system • Displays little concern for the future	*0 1 2 Omit*
Item 3: Manipulative • Manipulates without concern for the rights of others • Distorts the truth • Deceives with self-assurance and with no apparent anxiety • A fraud artist or con-man • Enjoys deceiving others	*0 1 2 Omit*
Item 4: Lacks Remorse • Appears to have no capacity for guilt: no conscience • Verbalises remorse in an insincere manner • Displays little emotion in regard to actions • Does not appreciate impact on others • More concerned with own suffering than with that of others	*0 1 2 Omit*
Item 5: Lacks Empathy • Cold and callous • Indifferent to the feelings or concerns of others • Unable to appreciate the emotional consequences of actions • Expressed emotions are shallow and labile • Verbal and non-verbal expressions of emotion are inconsistent	*0 1 2 Omit*
Item 6: Doesn't accept responsibility • Rationalises; downplays the significance of acts • Minimises the effects of behaviour on others • Projects blame onto others or circumstances • May maintain innocence or minimise involvement in crimes • May claim to have been framed or vicimtised; may claim amnesia or blackouts for events surrounding the offence	*0 1 2 Omit*

Part 2

Item 7: Impulsive • Does things on the "spur of the moment" (including crimes; spends little time considering the consequences of actions. • Frequently changes jobs, schools, or relationships • Is a drifter; lives a nomadic lifestyle, with frequent changes of residence • Is easily bores; has difficulty doing things that require sustained attention • Likes to do things that are exciting, risky, and challenging	*0 1 2 Omit*
Item 8: Poor Behavioural Controls • Is easily angered or frustrated, especially when drinking • Is often verbally abusive (swears and makes threats) • Is often physically abusive (breaks or throws things; pushes, slaps, or punches people) • Abuse may be sudden and unprovoked • Outbursts are often short-lived	*0 1 2 Omit*
Item 9: Lacks Goals • Does not have realistic long-term plans and commitments • Has lived day-to-day not thinking of the future • Has relied excessively on family, friends, and social assistance for financial support • Has poor academic and employment records • May describe far fetched plans or schemes	*0 1 2 Omit*
Item 10: Irresponsible • Behaviour frequently causes hardship to others or puts them at risk; unreliable as a spouse parent: lacks commitment to relationships, fails to care adequately for children, etc. • Job performance is inadequate: frequently late, absent, etc. • Untrustworthy with money: has been in trouble for defaulting from loans, not paying bills, etc.	*0 1 2 Omit*
Item 11: Adolescent Antisocial Behaviour • Had conduct problems at home and at school as an adolescent • Was in trouble with the law as a youth/minor • Antisocial activities were varied and frequent	*0 1 2 Omit*
Item 12: Adult Antisocial Behaviour • Disregards rules and regulations; has had legal problems as an adult • Has been charged with or convicted of criminal offences • Antisocial activities are varied and frequent	*0 1 2 Omit*

Part 1	
Part 2	
Total PCL-SV	

SVR-20

0 = no evidence
1 = possible/partial evidence
2 = evidence

Item 1: Sexual deviation evidence of stable, deviant sexual preference self-reported deviance or evidence from multiple acts	*0 1 2*
Item 2: Victim of child abuse Serious, sexual, physical abuse and neglect that resulted in substantial physical or psychological harm prior to the age of 17 years old Irrelevant whether perpetrated by family or stranger Includes exposure to domestic violence	*0 1 2*
Item 3: Psychopathy As defined by PCL-R or PCL-SV	*0 1 2*
Item 4: Major mental illness serious cognitive or intellectual impairment, psychotic disorder, or mood disorder *at any time in life* according to standardised DSM-IV criteria	*0 1 2*
Item 5: Substance abuse problems serious alcohol or substance abuse *at any time in life* to the detriment of individual or social functioning	*0 1 2*
Item 6: Suicidal/homicidal ideation thoughts, impulses or fantasies about self-harm or harm to others where persistent and intrusive and moderate to high level of intent at *any time in life*	*0 1 2*
Item 7: Relationship Problems multiple relationship breakdowns with marital or common law relationships; serious marital conflict including spousal violence; failure to establish intimate relationship	*0 1 2*
Item 8: Employment Problems frequent job changes or long term unemployment or instability in education of dependent	*0 1 2*
Item 9: Past non-sexual violent offences offences of actual, attempted or threatened non-sexual physical harm	*0 1 2*
Item 10: Past non-violent offence criminal history of non-violent offences, resulting in charge or arrest, or on several occasions	*0 1 2*
Item 11: Past supervision failure breach of bail, restraining order, community service, probation	*0 1 2*

Item 12: High Density Sex Offences frequent acts over a short space of time when the individual has had the opportunity	*0 1 2*
Item 13: Multiple Sex Offence Type offences vary in terms of victim selection, type and degree of contact with victim, and nature of coercion used	*0 1 2*
Item 14: Physical Harm to Victim in Sex Offences victim suffered bruises, cuts etc. and required medical attention as a result, while committing an act of sexual violence	*0 1 2*
Item 15: Use of Weapons or Threats of Death including firearms, clubs, knives, or other object and including threat of death to victim	*0 1 2*
Item 16: Escalation in Frequency or Severity of Sex Offences more acts committed recently than in the past, or escalation in severity of offending	*0 1 2*
Item 17: Extreme Minimisation or Denial of Offences Individual denies many or all past acts of sexual violence; denies personal responsibility; or denies serious consequences of past acts.	*0 1 2*
Item 18: Attitudes that Support or Condone Sex Offences political, religious or cultural beliefs that excuse coercive sex or sex with children. Attitudes can also be inferred from behaviour when based on a pattern rather than a single act	*0 1 2*
Item 19: Lacks Realistic Plans Individual's intentions concerning the community, employment. Only realistic if stable and explicit and likelihood of achieving	*0 1 2*
Item 20: Negative Attitude Towards Intervention drop-out of treatment, treatment shamming, poor attitude towards intervention	*0 1 2*

Total SVR-20	

Other

0 = no evidence
1 = possible / partial evidence
2 = definite evidence

Crossover	
Specialised	
homosexual	
associates with other paedophiles	

Case Study 1.

Cognitive behavioural treatment of clinical depression: a single case study.

Gary J D Macpherson

Submitted in part fulfilment of the degree of doctorate in Clinical Psychology at the University of Edinburgh

List of contents

Word Court: 3795

Introduction

It is acknowledged that clinical depression is one of the most common psychological conditions (Bradley, 1994), and depression has long been cited as 'the common cold' of psychology (Seligman, 1975). Studies suggest rates of major depressive disorder ranging from 2.2 to 3.5 per cent and rates of dysthymia varying from 2.1 to 3.8 per cent (Myers *et al.* 1984). Fennell (1991) estimates that 15-20 per cent of adults experience significant levels of depressive symptomatology at any given time while 12 per cent experience depression of sufficient severity to require treatment

Major depression is a disorder of mood or emotional symptoms, depressed thinking or cognitive symptoms, problems of motivation, and physical symptoms. A number of studies have examined the efficacy of treatment for depression, but it is only in the last two decades that controlled evaluations using psychological and pharmacological approaches to treatment have been completed (Bradley, 1994).

Cognitive therapy was described as a method of treatment for depression for outpatients with mild-moderate depressions (Beck *et al.* 1979). Intervention including cognitive therapy and anti-depressant medication is the acknowledged treatment of choice for a depressive condition and supported widely in the clinical and research literature (Blackburn *et al.* 1986; Murphy *et al.* 1984). The combination of cognitive therapy and antidepressant medication is known to prevent relapse in depression over the long-term (Hollon *et al.* 1992; Shea *et al.* 1996).

Referral

JK was charged with the murder of his step-father and placed on remand within H.M. Greenock Prison. He was interviewed by a Consultant Psychiatrist who found JK to have been experiencing a 'mild depressive illness over the last few months not amounting to a major form of mental disorder'. The basis for this diagnosis was unclear. JK was to be tried for murder. JK's defence solicitor requested that a more detailed report by a clinical psychologist on JK's condition be made available to the Court to allow the possibility of a defence of diminished responsibility to be raised. JK was assessed within H.M. Greenock Prison during September 1997.

Assessment

(a) Presentation

JK presented as a rather detached and emotionally flat individual. He had some difficulty expressing himself emotionally and this may have influenced the assessment of the psychiatrist. I gained the impression that JK was a practical man who did not possess a sophisticated language to describe internal experiences. There was no evidence at interview to indicate that JK was experiencing thought disorder or behaviour suggestive of a psychotic process. I could find no evidence at interview to suggest that JK was being evasive and I formed the impression that JK was open in his account to me.

(b) Relevant background information

JK was adopted at an early age. He had latterly considered attempting to contact his natural parents but had decided against this. He described no problems at school. JK left at age 15 years without obtaining any formal academic qualifications. His longest period of work was as a welder for eight years before he was made redundant. JK last worked offshore repairing oilrigs four years ago.

(c) Relationship history

JK had been married for 19 years although the marital relationship was becoming difficult to sustain. He expressed a significant degree of concern about his current situation and the possible detrimental effects of such on the relationship with his wife and son. He spent his time caring for his elderly stepfather. His account was that his stepfather was alcohol dependant and demanding when under the influence. This view was corroborated by information obtained from JK's General Practitioner.

(d) Alcohol and substance use

JK was an infrequent and moderate alcohol use. He alluded to a period of more heavy alcohol consumption during his working life but told me that he had never been a problem drinker. There was no evidence of prior experimentation with illicit substances.

Initial formulation

I formed the initial impression from his account and behaviour at interview that JK was experiencing a mood disorder consistent with a depressed state of mind. In order to assess the specific symptoms and the severity of any condition, I completed a comprehensive evaluation of JK's psychological condition and background functioning.

I formed the opinion that JK's psychological condition was consistent with diagnostic criteria for a Major Depressive Episode (296.32: DSM-IV, 1994). He reported having experienced the following in line with the standard diagnostic criteria:

A. Five or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. **Depressed mood most of the day, early every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g. appears tearful).**

   JK reported a feeling of low mood at the beginning of the year and maintained that he had lost his will to do anything. He told me that he felt as if most days were empty. His account is that he became tearful at night most days. It was

apparent at interview that JK was a rather emotionally controlled individual who seemed close to tears at several points throughout the assessment. On this basis, JK met the first criterion for Major Depressive Episode.

2. **Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).**

JK could not recall engaging in anything that he has enjoyed within recent months. He previously held an active interest in cycling and had cycled most evenings and weekends. On reflection he recalled only managing to go cycling twice in the past year, both times at the request of his son. He had no interest in his daily routine. JK reported a feeling of *"lethargy"* and general loss of interest in his usual activities. On this basis, JK meets the second criterion for Major Depressive Episode.

3. **Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.**

JK reported that he had lost over one stone in weight over the past year. His account is that his appetite has been changeable and that he has lost some interest in food in general. In my opinion, JK's appetite disturbance was not sufficient to meet the third criterion for Major Depressive Episode.

4. **Insomnia or hypersomnia nearly every day.**

JK indicated that his sleeping pattern was poor. He had no problems achieving sleep but found that he frequently had difficulties sustaining sleep for any period of time and was unable to return to sleep. He spent his time staring at the ceiling during the early hours. He appeared to be experiencing both middle and terminal insomnia. His account was that he used to sleep well and his pattern over the past year had been markedly different than before. On this basis, JK met the fourth criterion for Major Depressive Episode.

5. **Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down.**

JK told me that he has found himself pacing around with no apparent purpose. He described this feeling as *"an anxiety. A kind of worry"* which had been with him most days for the past year. He was unable to explain the origins of such a feeling. His account was that his wife had noticed he had been increasingly restless and agitated. On this basis, JK met the fifth criterion for Major Depressive Episode.

6. **Fatigue or loss of energy nearly every day**

JK told me that he had felt increasingly tired over the past year. He attributed his tiredness to his sleeping difficulties but found that he also lacked motivation to engage in any activities. He described periods of inactivity and fatigue. He reported occasions where he spent the majority of the day lying bed. In my opinion, JK did not currently show the degree of fatigue necessary to meet the sixth criterion for Major Depressive Episode.

7. **Feelings of self worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).**

   JK told me that he related feelings of worthlessness to natural ageing and his diminished employment abilities. I could not determine that he has felt excessively worthless or guilty over the past year. In my opinion, JK did not meet the seventh criterion for Major Depressive Episode.

8. **Diminished ability to think or concentrate, or indecisiveness, nearly every day (either subjective account or as observed by others).**

   JK told me that his concentration level had been poor for some time. He indicated that reading a newspaper was an arduous task. He found his concentration limited and his memory less efficient for the most simple of routines. He had been unable to make decisions on trivial matters where he had previously been decisive. It was apparent at interview that he had some difficulties sustaining sufficient concentration to follow the assessment. On this basis, JK met the eighth criterion for Major Depressive Episode.

9. **Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific plan for committing suicide.**

   JK's account is that he had considered committing suicide at the start of the year. He told me that he had bought a quantity of Paracetomol with the intention of overdosing. He was unable to explain why he had felt suicidal but recognised

that thoughts had not been far from his mind. He did not express any active suicidal intent at interview. In my experience, remand prisoners often attempt to conceal this aspect, as they would be placed under conditions of suicidal observation. On this basis JK met the ninth criterion for Major Depressive Episode.

I also formed the overall view that JK's symptoms had been causing him clinically significant distress and impairment in his social and occupational functioning

A copy of the report was made available to the Consultant Psychiatrist who re-examined JK and prepared a supplementary psychiatric report. This confirmed the opinion that JK was suffering from a Major Depressive Episode. The psychiatrist revised his opinion and stated *"I now believe that his condition is sufficient to have diminished his responsibility for the alleged offence"*. The Court instructed that a further clinical psychology report be prepared to estimate JK's response to psychological treatment for depression.

Formulation

I formed the opinion that JK was experiencing Major Depressive Episode of moderate severity. The onset of his condition began some 12 months previously and appeared to be associated with the critical incidents of unemployment and more recent marital disharmony.

I also ruled out the following competing hypotheses:

1. JK's symptoms were not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication)

2. JK's symptoms were not better accounted for by a general medical condition (e.g., hypothyroidism).

3. JK's symptoms were not better accounted for by a bereavement reaction.

4. JK reported no history of contact with mental health professionals or had experienced any psychotic symptoms at any time in life.

Assessment for psychological intervention

JK reported a number of negative automatic thoughts consistent with the cognitive triad first reported by Beck (1967). These included thoughts that he was useless and of no value (self), a strong feeling of hopelessness and an inability to change his current circumstances (current experience), and an entirely negative view of what lay ahead (the future).

Eliciting specific negative automatic thoughts from JK was a difficult process although it was evident that he held a dysfunctional assumption consistent with a global self-evaluation of himself as 'stupid'. He vividly recalled that his adoptive father had consistently scolded him and subjected him to physical abuse as a result of his 'stupidity', further stating that a natural son would not have been so foolish.

This dysfunctional assumption appeared to have surfaced in recent months due to JK's period of unemployment and the increased frequency of negative comments from his stepfather. The combination of these events had confirmed JK's assumptions about his self-worth and abilities.

Cognitive behavioural intervention

I consulted with JK's General Practitioner as I was confident that the combination of both a clinical psychological and medical approach would reduce JK's depressive condition in the immediate and longer term in line with the literature on the combined efficacy of cognitive behavioural therapy and anti-depressant medication (Hollon *et al.* 1992; Shea *et al.* 1996).

I initiated psychological intervention with JK as an outpatient at the Douglas Inch Centre. At the first session I completed the Hamilton Rating Scale for Depression (HAM-D; Hamilton, 1960). I considered this an appropriate measure for three reasons. First, the HAM-D is the scale most frequently used to measure the outcome of the acute treatment of depression (Bech, 1996). Second, Edwards et al (1984) found the HAM-D to be more sensitive to reflecting treatment changes in depressive symptoms than the widely used Beck Depression Inventory (BDI). Third, I considered there a risk that the BDI would suggest symptoms of depression to JK which he may then endorse in view of his circumstances: self-report measures may be vulnerable to faking in forensic contexts. Macpherson (1997) has indicated that psychological measures based on self-report require the individual to co-operate as there is a risk that certain individuals may attempt to falsify or exaggerate their responses.

JK obtained a score on the HAM-D which placed him in the 'major depression' range. I also wrote to JK's General Practitioner who provided JK with a prescription of anti-depressant medication following the first appointment.

I used a cognitive behavioural intervention with JK as an outpatient at the Psychology Department, Douglas Inch Centre over the course of 12 months. I used the rationale for behavioural and cognitive psychological intervention provided by Fennel (1991). This involves a four-step approach to intervention.

(a) Development of cognitive strategies

The first stage involved the development of cognitive strategies to decrease the amount of time JK spent ruminating unproductively on past and recent events. This involved distracting himself while writing a simple list of tasks that he thought needed completed or things he would like to do in the house and beyond while rating them as essential or not-essential. I also provided standard advice to assist in achieving a satisfactory sleeping pattern.

(b) Monitoring behaviour

The second stage involved adopting the techniques of monitoring behaviour through 'mastery' and 'pleasure', and activity scheduling. The day was divided into three parts and three different task were completed for each part. A typical day would be divided into a pleasurable activity (for example, purchasing a cycling magazine), a problem oriented task (fixing a bathroom tile), and an exercise based

activity (a short cycle ride). JK rated each separate task on each day for 'mastery' and 'pleasure' on a scale of 0-10.

(c) Cognitive-behavioural strategies.

The third stage involved cognitive-behavioural strategies. This formed the lengthiest part of treatment and involved eliciting and challenging JK's negative thinking in order to provide JK with insight and control over his thought processes. Negative thinking, particularly in relation to the self and the future, is a well-established characteristic of depression (Teasdale, *et al.* 1998). A collaborative approach to diary keeping was adopted and JK recorded a simple diary of situations, thinking, and mood state at the time of the event. Eliciting specific negative automatic thoughts from JK was a difficult process although is was evident throughout the sessions that JK interpreted life experiences consistent with selective abstraction and personalisation. He appeared to attend to the negative aspects of his reduced functioning as evidence that was not improving. He also reported a number of cognitions consistent with over-responsibility for events that had only limited connection to himself (for example, his son arguing with his mother). I was able to challenge these errors in thinking and provide a second record to complete which included a column for JK to write a more rational response to his negative thinking.

(d) Challenging dysfunctional assumptions

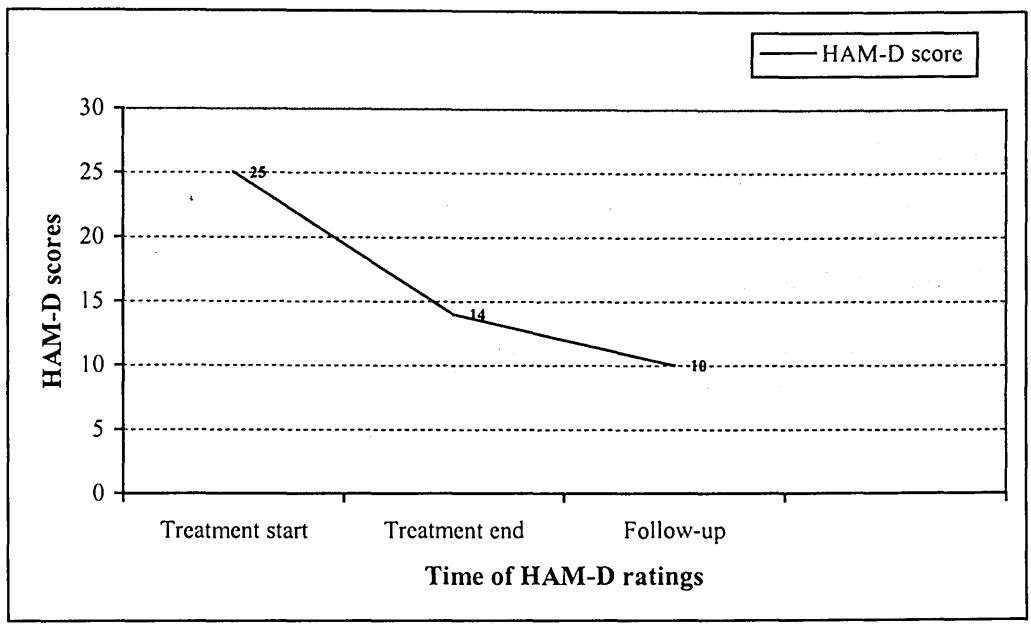
As a final stage, I considered it important to elicit the basis of JK's negative automatic thoughts. It was evident that JK held a dysfunctional assumption consistent with a global self-evaluation of himself as 'stupid'. He vividly recalled

that his adoptive father had regularly scolded him and subjected him to physical abuse as a result of his 'stupidity'. From an early age JK had accepted that he must have been stupid and formed the view that a natural son would not have been so foolish. The assumption appeared to have become apparent due to his period of unemployment which confirmed his belief that he was not of sufficient skill to sustain employment. The assumption was also partly confirmed by his wife's unfavourable comparison of their son's performance at school with the perceived lack of intelligence of his father. The family myth was that the son gained his intelligence from the mother. Challenging JK's assumptions revealed several facts. First JK had indeed been employed manually throughout his adult life. However, he worked in a particularly specialised occupation (oilrig welding) where he had obtained regular professional development. Second, JK's poor employability largely reflected changing patterns of employment within the West of Scotland rather than on a wider basis. JK was encouraged to test his assumptions by collecting all of his certificates and drafting a curriculum vitae for possible application to a wider employment forum.

Response to intervention

JK responded well to a cognitive behavioural approach over the course of his eight appointments at the Clinic as evidenced by his reported improvement in a number of domains, and as illustrated by the ratings made on the HAM-D at the first treatment appointment, at the end of seven treatment sessions, and at two-month follow-up (fig. 1).

Fig. 1. Clinician ratings of JK on the Hamilton Depression Scale at first treatment appointment, end of treatment, and two-month follow-up.



HAM-D Scores	Categories
0-7	No depression
8-12	Minor depression
13-17	Less than major depression
18-29	Major depression
30-52	More than major depression

from Bech (1996)

JK reported that his mood was no longer depressed and he appeared to be thinking with greater clarity. His account is that he had learned to challenge and change his previously depressed thinking style. JK was continuing to improve with regard to cognitive functioning and was able to read a novel for the first time in many months. His appetite was restored although I continued to note some difficulties with middle insomnia. Energy levels have improved considerably and he was cycling regularly. His levels of motivation had improved significantly as had his belief in his abilities, to the extent that he gained full-time employment as a welder in the Netherlands. It should be noted that JK was prescribed anti-depressant

medication although he was not compliant with medication and stopped taking antidepressants several weeks after prescription.

Summary and Conclusions

It would be wrong to suggest an entirely positive outcome for JK over the 12 months. JK continued to report intrusive thoughts about the crime. He maintained that he felt *"haunted"* and I gained the impression that he was continuing to adjust to the effects of his behaviour. This was appropriate given the nature of the crime. I also noted that his marriage had deteriorated as a result of his crime. He and his wife were considering a separation. In summary, JK has responded well to the psychological treatment and I was confident that JK had learned the necessary skills to prevent a relapse in his condition.

This case study further illustrates the applicability of cognitive behavioural therapy for clinical depression on an outpatient basis (Beck *et al.* 1979). JK had a successful outcome in the absence of concurrent medication. This was not a controlled case study and it is not possible to estimate the most effective component of treatment. In addition, it is difficult to know whether JK would have experienced improvement in his condition over the course of time without psychological intervention.

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Case Study 2.

Assessment and treatment of post-traumatic symptoms following a road traffic accident: a single case study.

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Submitted in part fulfilment of the degree of doctorate in Clinical Psychology at the University of Edinburgh

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Introduction

Road traffic accidents are the leading cause of death in those aged under 40 years in developed countries and a major cause of morbidity (Mayou, 1997). Despite this fact, there has been very little interest in the psychological consequences of road accidents. Most road accidents are not traumatic due to the brevity of the accident and only a minority of accidents are life threatening. Some road accidents do involve prolonged and frightening experiences involving threatened death or serious injury, and a threat to integrity.

Mayou *et al.* (1993) found acute, moderately severe emotional stress to be common in a series of 188 consecutive injured road accident survivors. Almost a fifth of the sample suffered from acute stress syndrome characterised by mood disturbance and intrusive memories of the accident. Anxiety and depressions were shown to improve for many of the survivors by the end of the year. A significant minority were found to have specific post-trauma symptoms including driving phobia or anxiety.

Blanchard *et al.* (1995) assessed 158 survivors of car accidents who sought medical treatment between one and four months post-accident. Sixty-two accident survivors (39 per cent) met the Diagnostic and Statistical Manual of the American Psychiatric Association-Third Edition-Revised (DSM-III-R, 1987) diagnostic criteria for Post-Traumatic Stress Disorder (PTSD). Accident survivors who developed PTSD were

also found to be more subjectively distressed and reported more impairment in their performance at home and work compared to accident survivors who did not meet criteria for PTSD.

The following case report examines the psychological assessment and cognitive behavioural treatment of an individual a change in psychological functioning following a road traffic accident.

Referral

SM attended for psychological assessment at the request of the Chief Medical Officer of a major police force. He was referred to me in my capacity as Force Psychologist to the police. SM was a Police Constable in the traffic department and had been involved in a road traffic accident in which he sustained physical injury. An assessment of any psychological sequelae resulting from the accident was required.

Psychological assessment

The psychological assessment was directed at determining whether SM had suffered from a significant psychological condition related to car accident. I have also outlined the cognitive behavioural treatment provided for SM.

Behaviour at interview

SM presented as a friendly and co-operative young man at interview. He was able to discuss neutral or background topics and related appropriately. However when I approached the subject of the accident he behaviour became visibly more agitated, his eyes began to water, and he appeared to have some difficulty relating events to me in an emotionally controlled manner. I gained the impression that SM was continuing to experience difficulties coming to terms with aspects of the accident. He appeared to be open in his account to me and I formed the impression that he was not trying to be evasive or misrepresent himself or his behaviour.

SM's account of the accident

SM told me that he had been involved as a passenger in a car accident while engaged in traffic police operational duties. He told me that he had been driving for the first half of the shift until a refreshment break and his colleague took the wheel. He recalled a Montego car overtaking them at speed and they pursued the car with the expectation that the driver would stop. However the car picked up speed at this point. SM used the police radio and recalled that the operator was asking for a registration number for the car. SM's account was that they were travelling at an estimated speed of 95 - 100 m.p.h. They continued to pursue the car for approximately one-mile before cornering a left bend. SM told me that he *"saw panic in his (colleagues) face as the car danced in the road"* while the driver attempted to control the skid. The police car then collided with a parked vehicle.

SM's next account was of experiencing *"severe pain"*. He told me that air had been forced out of his lungs and he recalled cutting the seat belt with a standard safety device inside the car. He was unsure whether he made an attempt to exit the car but recalled feeling unable to move. His next recollection was of floodlighting and a blanket being put over his head while the Road Rescue Unit began to cut the roof from the car. He recalled being asked to move by the ambulance man but again felt that he was unable to. SM told me that he had only two or three minutes of memory for this period. He later learned that he had been at the site of the accident for approximately one-hour and his gaps in memory were explained by his varying degrees of consciousness. SM told me that he thought he was going to die. His account is that he could not breathe as a result of damage to his ribs and felt as if he was drowning in blood.

Psychological condition

Individuals who experience an event of this severity, that is a life-threatening event, in which someone close to them is threatened with death or severe injury, may develop Post-Traumatic Stress Disorder as a result of the event. Post-Traumatic Stress Disorder is defined under DSM-IV (1994) in terms of six specific criteria (see below):

Diagnostic Criteria for 309.81 Post-Traumatic Stress Disorder

A The person has been exposed to an event in which both of the following were present:

1) the person experienced, or witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of others.
2) the person's response involved intense fear, helplessness, or horror.

B The Traumatic event is persistently re-experienced in one (or more) of the following ways:

1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
2) recurrent distressing dreams of the event (acting or feeling as if the Traumatic event were recurring (includes a sense of relieving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
3) intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the Traumatic event.
4) physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the Traumatic event.

C Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three (or more) of the following:

1) efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2) efforts to avoid activities, places, or people that arouse recollections of the trauma.
3) inability to recall an important aspect of the trauma.
4) markedly diminished interest or participation in significant activities.
5) feeling of detachment or estrangement from others.
6) restricted range of affect (e.g. unable to have loving feelings).
7) sense of foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span).

D Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1) difficulty falling or staying asleep
2) irritability or outbursts of anger
3) difficulty concentrating
4) hypervigilance
5) exaggerated startle response

E Duration of the disturbance (symptoms in Criteria B, C, and D), is more than one month

F The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Acute Post-Traumatic Stress Disorder: if duration of symptoms is less than three months.
Chronic Post-Traumatic Stress Disorder: if duration of symptoms is three months or more.

Initial Formulation

I formed the initial view from his presentation and account at interview that SM was experiencing symptoms suggestive of Post-Traumatic Stress symptomatology. In order to clarify the range of his symptoms and extent of any psychological condition I completed a thorough review of his psychological functioning and considered each of the six criteria above.

A. The person has been exposed to a traumatic event to which they have responded with both fear, helplessness, or horror.

SM's account of the accident was consistent with the first criterion for Post-traumatic Stress Disorder. In particular, SM was convinced that he was going to die. His description of his reactions at the time is consistent with feelings of fear, helplessness, and horror.

B. The traumatic event is persistently re-experienced.

SM reported that he re-experienced the accident in several ways. He told me that he experienced intrusive recollections surrounding aspects of the accident on his return to work. SM told me that he did not experience distressing dreams about the accident. His account was that he recalled aspects of the accident when he heard a commentary on a vehicle pursuit from the police radio. He reported a history of flashbacks following the accident although these had passed by the time of his attendance. I could elicit no dissociative experiences as if the accident were recurring. SM told me that he initially felt *"terrible feelings"*

when he was involved in a pursuit on his return to work. I noted that he was physically sick on one occasion following a pursuit and in general appeared to have become more concerned about the driving ability of his colleagues. SM gave a detailed account of the physiological symptoms associated with his initial response to the accident. He told me that his heart raced and he felt physically shaky when engaged in a vehicle pursuit.

On the basis of the above, SM met the second criterion for Post-Traumatic Stress Disorder.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness.

I gained the impression that SM was continuing to avoid stimuli associated with the accident in a number of ways. He told me that he had rarely spoken about the accident. He recalled that he had been in tears when first interviewed regarding the accident. I noted that he had began to use alcohol more frequently and in increasing amounts in order to achieve relaxation. SM told me that he had not been avoiding his usual activities and had returned to police driving. He appeared to have lost some enthusiasm for his police duties although he related this to his feelings of a lack of support from his supervisors rather than a direct effect of the accident. I did not gain the impression of any feelings of detachment or estrangement from others. SM's affect did not appear to be restricted in range. SM did not present with a sense of foreshortened future although he reported a tendency towards pessimism.

On the basis of the above SM did not meet the third criterion for Post-Traumatic Stress Disorder.

D. Persistent symptoms of increased arousal.

SM reported a number of symptoms indicative of an increased arousal. He told me that he had problems concentrating and was generally more irritable with his wife and with other drivers in general. His sleeping pattern appeared to have been characterised by hypersomnia although I noted no distinct change in his sleeping habits. He described a sense of increased caution when driving rather than a hypervigilance. I did not elicit any examples either from SM himself or at interview to suggest an exaggerated startle response.

On the basis of the above, SM did not meet the fourth criterion for Post-Traumatic Stress Disorder.

Formulation

I formed the opinion that SM's psychological condition was suggestive of several features consistent with but not amounting to a diagnosis of Post-Traumatic Stress Disorder as a direct result of his involvement in the road traffic accident.

I also ruled out the following competing hypotheses:

1. SM's symptoms were not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication)

2. SM's symptoms were not better accounted for by a general medical condition (e.g., hypothyroidism).

3. SM reported no history of contact with mental health professionals or had experienced any psychotic symptoms at any time in life.

4. SM was not experiencing any co-morbid psychological condition such as clinical depression or generalised anxiety. These conditions are often reported in the aftermath of road traffic accidents (Atchison and McFarlane, 1997).

In addition to his post-traumatic symptoms, SM's account suggested a marked anxiety concerning travelling by car, characterised by increased caution and alertness to the behaviour of other road users. This is one of the most common reported consequences of road accidents (Mayou, 1997). I formed the view that his level of anxiety was sufficient to amount to diagnostic criteria for a specific phobia (DSM-IV, 1994) of moderate severity relating to travel by car.

Cognitive behavioural intervention

SM attended for psychological intervention on six subsequent occasions. Following the assessment, I asked SM to complete several measures as a baseline to measure change in his general functioning. I used the 12 item General Health Questionnaire

based on the full GHQ (Goldberg 1978), the Beck Depression Inventory (Beck, 1988) and the Beck Anxiety Inventory (Beck, 1990).

(a) Introduction of cognitive techniques

A cognitive behavioural treatment was initiated in line with the clinical and research literature on the treatment of post-traumatic symptomatology in general (McFarlane, 1989) and following road accidents in particular (Hickling *et al.* 1997). The treatment approach encouraged the use of cognitive techniques to explore perceptions of the accident and encouraged the conscious re-experiencing of salient features of the accident. SM recounted the accident in detail during the initial sessions at the clinic.

(b) Desensitisation

SM also tape-recorded his account of the accident and played this at home between sessions. The rationale for this was to allow SM to confront the accident while coping with the associated unpleasant feelings. I also reinforced SM during the process for his positive efforts.

(c) *In vivo* exposure

I also identified appropriate targets to counteract avoidance behaviours. This included a short hierarchy of exercises to encourage SM sit as a passenger in a car for extended periods. This is the standard behavioural method of *in vivo* exposure and is considered as the most effective treatment approach for post-trauma phobic avoidance in reviews of the literature (Kent, 1991; McFarlane, 1989). As treatment progressed it was observed that there were no significant difficulties with SM when

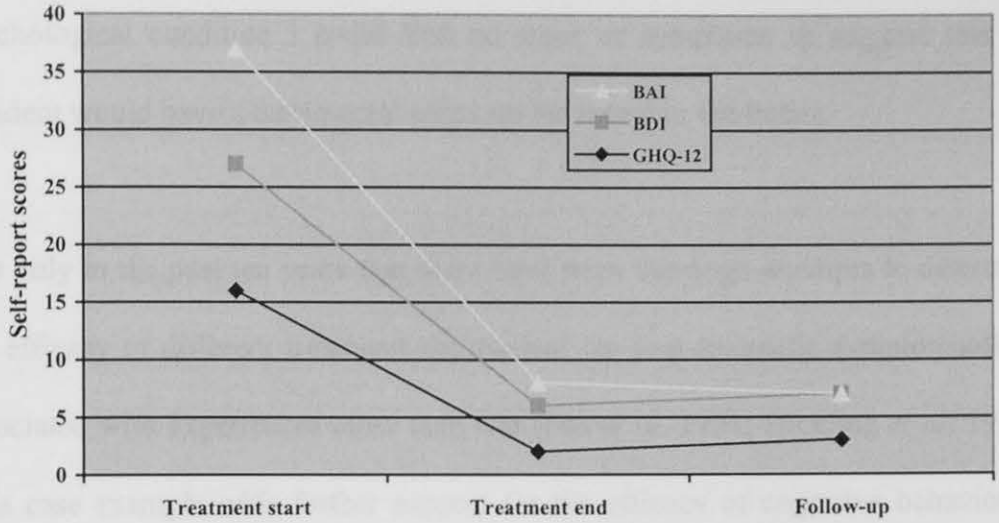
he was the driving a car. However, when SM was a passenger he experienced acute levels of anxiety. Progressive muscular relaxation was taught during one session and practised on a daily basis at home via a tape. SM was able to apply this approach to decrease the physiological arousal experienced as a passenger. He also attended for physiotherapy and advice on exercise was offered appropriate to his level of physical functioning in order to further reduce levels of physical tension.

At the final session, SM's own account at point of discharge suggested an improved ability to relax, little by way of intrusive thinking, and an absence of the anxiety previously associated with the accident. In general he was enthusiastic about his return to work and I was of the opinion that SM's continued attendance was not necessary. SM was in full agreement with discharge at this stage.

Response to psychological intervention

I had the opportunity to review SM's psychological condition with him some eight months after discharge (which coincidentally was the anniversary of the car accident). This allowed a follow-up data to be collected and compared to baseline and post-treatment self-report (table 1: below).

Table 1. SM's self report on the GHQ-12, BDI and BAI at first treatment appointment, end of treatment, and eight month follow-up.



The above table demonstrates that SM's self-reported improvement on the standard measures and the sustained gains over the eight-month follow up period. SM continued to report a caution and alertness to other road users when a passenger or driver in a police vehicle in comparison to pre-accident levels. This had decreased in intensity over the previous months and it was my view that it would continue to do so. SM told me that he was satisfied with his current police duties and this was corroborated by an excellent recent appraisal of his police duties.

Discussion

The psychological impact of an accident varies as a function of the severity of the trauma and the relative importance of the event (Foa *et al.* 1995). In this particular case, SM was motivated to seek treatment for his symptoms and reported no significant psychological symptomatology associated with the accident at discharge. The long-term prognosis of individuals who have experienced

psychological symptomatology as a result of a traumatic event can be characterised by an increased vulnerability for the future. From the perspective of SM's psychological condition I could find no signs or symptoms to suggest that the accident would have a detrimental effect on his future in the Police.

It is only in the past ten years that there have been thorough attempts to determine the efficacy of different treatment approached for post-traumatic symptomatology associated with experiences other than war (Foa *et al.* 1991; Hickling *et al.* 1997). This case example adds further support for the efficacy of cognitive behavioural intervention approaches with road traffic accident survivors.

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Case Study 3.

Competence to stand trial and fairness of a confession obtained by the Police from an accused person with a learning disability: a functional approach to assessment.

Gary J D Macpherson

Submitted in part fulfilment of the degree of doctorate in Clinical Psychology at the University of Edinburgh

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Introduction

The Scottish law on the admissibility of confession evidence differs significantly from English law. It has to be established that a confession was fairly obtained before a Scottish court will admit this as evidence in a criminal trial. The historical judicial antipathy towards confession evidence obtained the police has been replaced by an increased legitimacy of accepting confession evidence within Scottish courts. Police procedures have also changed and now routinely include taped-recorded confessions and an increased use of video taped evidence of confessions made by accused persons.

Historically, the courts have accepted the competence of an accused person to stand trial has been based on the opinion of psychiatric evidence. It has been argued that psychiatrists fail to appreciate the difference between their normal diagnostic approach and the functional approach required in a legal context (Grisso, 1986). A global diagnosis provides little information about an individual's capacities (Cooke and Carlin, 1996). Clinical psychologists have an increasing role in assessment for criminal justice purposes (Macpherson, 1997*a*) and this extends to the psychologists' expertise in the assessment of cognitive capabilities in general and intellectual functioning in particular (Gudjonsson, 1992). Gudjonsson (1992) has also observed that the courts are increasingly admitting psychological evidence. It is within this context that the current assessment was conducted.

Referral

GM was charged with two offences of a sexual nature against one younger and one older male. A crown psychiatrist initially found the accused sane and fit to plead but changed this opinion under cross-examination and testified to GM's tendency to defer to authority figures. The defence counsel asked for a clinical psychologist to complete an assessment of the GM's vulnerabilities and determine whether he would be competent to stand trial and whether the police taped confession evidence was admissible.

Instruction was received from GM solicitor and he was interviewed on two occasions while on remand. The psychological assessment was directed at five issues. First to determine GM's level of intellectual functioning. Second, to determine GM's understanding of the charges against him. Third, to determine GM's understanding of the terms of the Police caution and his account of the Police interviews. Fourth, to determine GM's level of suggestibility. Finally, to form an opinion on GM's competence to stand trail. I had access to copies of transcripts of Judicial Examinations, police taped transcripts and tape recording of these transcripts which related to several confessions GM had made to the Police under interrogation.

Psychological assessment

The first part of the assessment concerned GM's competence to stand trail. The second concerned the admissibility of the Police taped alleged confession.

Behaviour at Interview

GM presented at interview in as a timid man with whom conversation was a difficult proposition. He grimaced a number of times throughout the assessment for no apparent reason. He appeared to find the interview a challenging experience. He did not appear to be clinically depressed or anxious at interview. There was no evidence that he was experiencing thought disorder or behaviour suggestive of a psychotic process. There were no indications that he was being evasive and my impression was that he co-operated with the evaluation and appeared to try hard with the psychological tests. His use of language was limited and often consisted of poorly formed sentences after a lengthy delay. It was immediately apparent at interview that GM's level of intellectual functioning was not high.

Relevant background information

GM was a poor historian as regards his background. He was able to tell me where he was born and recalled being placed into a hospital for individuals with a learning difficulty at the age eight or nine years old. He was unable to remember why he had been placed in the hospital. He spent later years in a series of children's homes and attended for special education. He was living in supported accommodation at the time of the assessment.

I attempted to gain an understanding of his capacity on a social level. He told me that he could not read but could write. I noted however that he was initially unable to spell his second name. He appeared to have little concept of money and told me that he relied on his Social Worker or another responsible individual to look after his finances.

Part A: Psychological assessment of competence to stand trial

The overall competence of an individual to stand trial is dependent on issues concerning sanity and issues concerning fitness to plead. In this particular case, there were no indications that GM was experiencing a psychotic process or mental illness. It was apparent however that GM was not able to instruct his defence due to his low level of intelligence.

To objectively establish GM's level of intellectual functioning I assessed him using a standard psychological test. I used the Wechsler Adult Intelligence Scale - Revised (WAIS-R; Wechsler, 1981). This is the standard procedure for assessing level of intellectual functioning. It is a valid and reliable test consisting of eleven distinct subtests scored in a standard way. The procedure takes between 60 to 90 minutes to administer. The WAIS-R is a well-established and accepted means of estimating levels of intellectual functioning (Silverstein, 1982).

GM's overall level of intellectual functioning was in the 'Mentally Handicapped' range (Full Scale IQ = 58). GM's overall level of intellectual functioning places him below

1% of the general population. Thus 99% of the population can be regarded as having a higher level of intellectual functioning than GM.

It is conventional to quote IQ figures for individual cases with confidence limits to calculate the likely range of the estimate. Estimating the 95% confidence intervals for GM's Full Scale IQ of 58 indicates that there is a 95% probability that his true score lies in the range of 54 to 64.

The Professional Affairs Board of the British Psychological Society (BPS; 1991) has indicated that low intellectual functioning in the range of between 55 and 69 is consistent with **"significant impairment of intelligence"** as this term is used as part of the definition of mental impairment within the Mental Health (Scotland) Act 1984. Intellectual functioning of 54 and below is consistent with **"severe impairment of intelligence".**

The Professional Affairs Board of the BPS also emphasise the importance of assessing social functioning in reaching a definition on mental impairment. Unfortunately there does not exist a precise definition of impaired social functioning. The BPS recommend that the term might be interpreted as an individual's abilities to independently provide for oneself, provide for one's sustenance, and to keep oneself clean, warm and clothes. I noted that GM was unable to read or write. He appeared unable to perform simple tasks of addition or subtraction. He appeared to have no concept of money and told me that he relied on his brother to look after his finances. He was unable to cook a simple

meal and I could find no evidence of him ever having lived independently. I formed the overall view that he met the intent of the definition of impaired social functioning as provided by the BPS.

GM's level of intellectual functioning placed him in the range of significant impairment of intelligence.

I was confident that this was a reliable estimate of GM's intellectual functioning for two reasons:

1. The Wechsler Adult Intelligence Scale - Revised is composed of eleven subtests. Using a standard computer programme to score the test, only one of the scores contributing to GM's Verbal IQ differed significantly from his average verbal score. Therefore the Verbal IQ is a good indication of his abilities in this area.

2. Secondly, none of the scores contributing to the Performance IQ differed significantly from his average Performance score. Again this suggests the Performance IQ to be a good indication of GM's abilities in this area.

Philip and Cooke (1999) suggested a number of ways in which the WAIS-R might potentially be faked. These include minimal responding, irregular performance atypical responding, and non-compliance. Macpherson (1997*b)* has also discussed the strategies

that individuals employ to fake or exaggerate impairment during psychological testing. I found no evidence of these strategies and this further enhanced the validity of the result obtained on the WAIS-R.

Understanding of the charges against him

GM told me that the charges involved his nephew. He appeared to have a poor memory of the alleged offence. He did tell me that he had *"done something what I shouldn't done"*. I then attempted to ascertain what he meant by this. He told me *" it is hard to remember what it is. As soon as someone visit they tell you you've done something wrong"*. From this account, I formed the view that GM did not appreciate the totality of the charges against him. I therefore asked GM specific words contained within the charges against him to estimate whether he might understand part of the charges. He was unable to provide answers to most of the words contained within the charges. I formed the impression that GM did not have an understanding of the alleged offending behaviour as expressed in the charges in total or when the charges were broken into a more simple language.

Understanding the basic elements of the legal system

From GM's behaviour at interview and understanding of language, I gained the impression that he might also have significant difficulties in his competence to assist in his defence or capacity to understand the basic elements of the legal system. I therefore asked GM to provide me with his understanding of certain legal terminology. He provided the following answers (Table 1):

Table 1. Legal terminology and GM's responses.

'Judge'	*"Who is the highest person of the high of the Court. He also asks the questions. The one who answers questions out."*
'Advocate'	*"Like someone who sits opposite and types the details out. They just sit and wait"*
'Solicitor'	*"He defends from you for the other people. He comes and visits"*
'Plea'	*"The jury decide that you are pleading and they put you in prison. "*
'Trial'	*"Someone who is up before you. You wait next. It means witnesses too"*
'Jury'	*"The ones who decide if they talk to everyone to see what is going to happen".*
'Indictment'	*"The sheet of paper that tells you what time you've got to be up at."*

I formed the opinion based on these answers that GM did not have a sufficient understanding of the basic elements of the legal system or the individuals involved in the legal process.

GM also showed a significant lack of understanding of his situation as a defendant in a criminal prosecution and capacity to make a competent decision in his defence. GM was unable to provide me with an intelligible answer when asked what the difference was between pleading guilty and going to trial. After a lengthy delay he explained, *"Trial is different than guilty. The defenders. That means you getting sentenced until they decide what is going to happen to you"*. Nor was GM able to provide an intelligible answer for the reasons someone might decide between these two choices.

The psychological assessment indicated that GM met the standard criteria for significant impairment as defined under the Mental Health (Scotland) Act (1984). In addition from the case of Stewart (1997) established that the legal test of competence was:

> **"Whether the appellant, by reason of his mental handicap, would be able to instruct his legal representatives as to his defence or to follow what went on at his trial. Without such an ability he could not receive a fair trial"**

The case of John James Alexander Stewart –v- HMA (SCCR 1997 330) established that the accused must have a clear understanding of the practical operation of a trial or matters that could arise during the trial. I formed the opinion that GM did not have a grasp of the nature of his situation or the consequences of various actions he might have taken to defend himself.

The following conclusions were drawn from the first part of the psychological assessment.

1. GM's level of intellectual functioning was in the 'Mentally Handicapped' range. He functioned within the bottom 1% of the general population with regard to intelligence.

2. GM's level of intellectual functioning was consistent with **"significant impairment of intelligence"** as this term is used as part of the definition of mental impairment within the Mental Health (Scotland) Act 1984.

3. GM did not have an understanding of the alleged offending behaviour.

4. GM did not have a sufficient understanding of the basic elements of the legal system, a grasp of the nature of his situation, or the consequences of various actions he might have taken to defend himself.

Based on the above psychological evidence relating to GM's level of intellectual functioning and understanding of the basic elements of the legal process, the High Court Judge ruled that GM was unfit to plead.

Part B: Admissibility of GM's alleged confession to the police.

When an individual is deemed unfit to plead in a Scottish court, a process know as Examination of the Facts (EoF) is conducted. EoF was established by the Criminal Procedures (Scotland) Act of 1995 and involves the trial proceeding as usual in the absence of the accused person giving evidence where it has been established that the accused has been found unfit to plead.

The Police taped interview

GM told me that he recalled being interviewed on one occasion by the Police. He had in fact been interviewed twice. On one occasion the interview had taken place in the presence of a Social Worker acting as a 'responsible adult'. He estimated that the interview lasted three minutes, when in fact both interviews lasted approximately one hour. GM told me that he had been upset during the interview and this was apparent from listening to the taped confessions. He became tearful throughout ht interview and it was apparent that he had a low level of understanding of the questions put to during interrogation. He could not recall any specific questions and his overall memory for the interviews appeared to be poor.

Understanding of the Police Caution

Research indicates that level of understanding of the Caution is significantly associated with intellectual functioning (Gudjonsson *et al.* 1994). The semantic and syntactic complexity of the Scottish Caution is a significant barrier to understanding. Using a sample of convicted young offenders, Cooke & Philip (1998) found that level of understanding was associated with intelligence in general and verbal intelligence in particular. They found that those individuals with impaired intellectual functioning are particularly disadvantaged in their understanding of the Caution.

It is customary for the Police to issue a caution to an accused person before proceeding with questioning. I asked GM if he knew what I meant by 'being cautioned'. He said *"Caution. Caution. Caution. Is it like someone that goes to the Church?"*.

Unlike the caution delivered under English law, the Scottish caution is not uniform although it almost invariably conforms to the following:

> **"You are not bound (obliged) to answer, but if you do answer, your answers may be noted, and may be tape-recorded, and may be used as evidence against you. Do you understand?"**

I read the Police caution contained within the transcript of the police interview to GM to ascertain his understanding of this. I asked him if he understood this. He replied *'Yes'*. I therefore asked GM what was meant by the Police caution. I was not of the impression that he was able to comprehend the meaning of the Police caution. He explained *"they are going to help people and look after the public and all that. Anything wrong they goes sort it out"*. I also asked if he recalled 'being cautioned' and he could not remember.

Following the rationale of Cooke & Philip's (1998) study to determine comprehension of the caution, I then read elements of the caution to GM in short individual sentences and asked GM to provide meanings for words contained within the caution to ascertain his understanding of these terms. GM was not able to give me accurate meanings for any of the individual words contained in the caution such as 'bound', 'noted', or 'right'. Further evidence of GM's limited abilities with language was evident during the test of intellectual functioning using the WAIS-R. During testing, GM was able to

provide meanings for simple words such as 'bed' 'ship' and 'penny', but unable to give meanings to slightly more advanced words such as 'winter' or 'breakfast'.

I gained the impression from his overall responses that GM did not have an accurate understanding of the terms of the caution or an appreciation of his legal rights as expressed in the caution, in particular his right to remain silent.

I assessed the likelihood that GM would make false, self-incriminating statements when questioned by police. The extensive research of Gudjonsson (1992) demonstrates that characteristics such as low intelligence and suggestibility increase the likelihood that an individual will make false, self-incriminating statements. Suggestibility is relevant to an interview if the individual is asked leading questions or was placed under pressure by the interviewer, for example by repeated questioning or negative feedback. Therefore, I considered GM's level of suggestibility directly using the Gudjonsson Suggestibility Scale (Gudjonsson 1987).

The Gudjonsson Suggestibility Scale was designed to determine the influence, which both the pressure of police questioning and the form of questions used, may have on the reliability of an individual's statements. The test identifies people who are particularly susceptible to giving erroneous accounts when subject to questioning. It is a standardised test, delivered in a standard way, and scored in a standard way, and the individual's performance is compared with the performance of a normative sample of people who have been measured using the same procedures. The Gudjonsson

Suggestibility Scale is acknowledged as a highly reliable and valid test of interrogative suggestibility (Gudjonsson, 1997; Gudjonsson, *et al.* 1995; Gudjonsson and Clare, 1995).

Research indicates that there are two types of suggestibility that may be measured. The first is the extent to which an individual will 'yield' to leading questions. The second is the extent to which the individual will 'shift' or change their replies once interpersonal pressure in the form of negative feedback is applied. The Gudjonsson Suggestibility Scale was developed to allow both aspects of suggestibility to be measured.

The administration of this procedure requires the subject to listen to a short passage and then he is asked to recall the details of the passage (immediate free recall). Fifty minutes later the subject is asked to recall the passage again (delayed free recall). These two scores provide an estimate of the functioning of an individual's memory. The subject is then asked a series of 20 questions about the passage, 15 of which are subtly misleading. The questions include open questions, leading questions, and questions which require the subject to choose between false alternatives. The extent to which an individual gives in or 'yields' to these misleading questions provides one measure of an individual's vulnerability to questioning.

Following completion of the twenty questions the subject is told clearly and firmly that **"You have made a number of errors. It is therefore necessary to go through the questions once more, and this time try to be more accurate".** The twenty questions

are then repeated and any significant change in an individual's responses provide a measure of the individual's tendency to 'shift' or change their account under pressure.

GM obtained a 'yield' score on the Gudjonsson Suggestibility Scale which placed him in the top 5% of the general population. This indicates a statistically abnormal tendency to go along with leading questions and is consistent with the literature on the negative relationship between the GSS and intellectual functioning (Gudjonsson, et al. 1995; Gudjonsson and Clare, 1995). The scores also suggested that he has a significant propensity to 'shift' or change his account under police pressure. His score places him within the top 5% of the general population in terms of his susceptibility to change his responses when placed under interpersonal pressure.

GM's total suggestibility score, a score that takes into account both his propensity to go along with leading questions, and to yield to interrogative pressure, placed him in the top 5% of the general population indicating that he is an abnormally suggestible individual. This may raise doubts about the validity of any statements that he made to the Police.

GM also exhibited a marked ability to confabulate on the Gudjonsson Suggestibility Scale. Confabulation refers to problems in memory where people replace gaps in their memory with imaginary recollections they believe to be true. Confabulation can be measured on the Gudjonsson Suggestibility Scale by recording information that has been added to the story (fabrications) or major distortions in the content of the story.

On assessing GM's total level of confabulation it is apparent that he has a markedly abnormal propensity to confabulate, falling within the top 5% in comparison to the general population. This finding raised further doubts about the accuracy of the statements that GM made during the police interviews.

The conclusions drawn from the second part of the assessment were as follows:

1. GM was unable to comprehend the police caution and did not appreciate his legal rights as expressed in the caution.

2. GM's performance on the Gudjonsson Suggestibility Scale placed him in the top 5% of the population and indicated that he was a significantly suggestible individual. This raised doubts about the reliability of the statements that he made to the Police during interrogation.

3. GM exhibited a significant propensity to confabulate, falling within the top 5% in comparison to the general population. This finding raised further doubts about the accuracy of the statements that GM made during the Police interviews.

Two conclusions were drawn from the overall psychological assessment. First, GM was not competent to stand trail due to his significant impairment of intelligence and his inability to understand court proceedings or the practical operations of a trial. Second, there was a significant risk that GM would provide false, self-incriminating

statements due to his inability to understand his right to remain silent as expressed in the police caution, and his significant degree of suggestibility and compliance. The Judge ruled that the accused could not have reasonable understood the police caution. In addition, GM's vulnerabilities, including his impaired intelligence and significant suggestibility, rendered the police evidence inadmissible. The accused was acquitted and liberated.

Discussion

Gudjonsson (1992) has commented in detail regarding the relationship between intelligence, suggestibility, and the effects of this on the ability to participate in the legal process as a witness or accused person. The case of GM confirms the negative relationship between learning difficulty and suggestibility. The Gudjonsson Suggestibility scales represent the best example of forensic assessment instruments that have been developed in the UK (Cooke and Carlin, 1998). The vulnerabilities of a person with low intellectual functioning involved in the Criminal Justice System should be a consideration during psychological assessment due to the influence that low intelligence has on responding during the interrogative process. Gudjonsson (1990) observed that the purpose of psychological assessment is to identify specific vulnerabilities which may have legal and clinical significance. Problems may arise when vulnerable individuals are placed under pressure during interrogation.

In addition, the current case study demonstrates that competence to stand trial can be reliably determined using a functional psychological approach to assessment with a

person of limited intellectual functioning. Grisso (1986) has observed that a functional approach rather than a diagnostic approach is required for legal decision making.

The case of GM also illustrates the importance of psychological evidence within a forensic context. The training of psychologists and their specific abilities to use and interpret psychometric tests are a particular advantage in legal settings, offering an objective measurement derived from psychological theory unlike any other discipline. The law has traditionally sought advice on psychological matters from psychiatrists with the consequence that courts receive less than adequate psychological advice on psychiatric matters. As Thomas-Peter and Warren (1999) have noted, legislation, and strong medical lobby in parliament only reinforces this error. Clinical psychologists applying psychological theory and research potentially have much to contribute to legal decision making.

Author's note:

Following the case of GM, the author presented expert evidence as reported in the case of Stephen McLachlan -v- Douglas Brown (SCCR 1997, 457) which established in law:

> "that a psychiatrist who is asked to give an opinion on someone's fitness to plead because of mental impairment may well be able to do so by having regard to the views of a clinical psychologist who has carried out an examination" SCCR 1997 p. 457.

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Legal cases

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Case Study 4.

Assessment of risk of violent recidivism using the Historical Clinical Risk-20 Scheme for assessing risk of violence: A single case study.

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Submitted in part fulfilment of the degree of doctorate in Clinical Psychology at the University of Edinburgh

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Introduction

There has been a marked increase in risk assessment and the prediction of dangerousness in the past decade (Monahan and Steadman, 1994), and Cooke (1998) has commented that risk assessment is now central issue in the care and management of the aggressive offender. Recent research has provided instruments for the assessment of risk among offenders that have improved the accuracy of risk predictions made from clinical impression alone (Borum, 1996).

Static predictors have much greater empirical support than dynamic variables and many studies are available to demonstrate the power of actuarial variables in the prediction of recidivism (Webster, et al., 1997). *Historical* (background) factors are said to be static in nature because they comprise factors that cannot change or rarely change over time. Cooke and Michie (1996) were able to achieve a 'hit' rate of 83% accuracy in predicting reconviction of a prisoner population within two years using an actuarial model, stressing the value of simple, readily accessible actuarial variables over complex clinical ones.

A central problem when risk is predicted by static predictors alone, is that level of risk remains constant. Risk is not a static concept, it is a dynamic variable. Consequently, interventions designed to reduce recidivism on release may show no effect on predicted level of risk. The low base rate of serious offences adds further

difficulty to accurate risk assessment. *Clinical* (or dynamic) factors are therefore considered dynamic and subjected changes as a function of the course of mental disorder or treatment (Grann, 2000). Dynamic factors are of interest to the clinician because they are the focus of supervision and treatment and involve issues about which in principle something can be done to modify level of risk. *Risk management* factors are increasingly considered in the risk assessment process in order to manage risk in institutions or in the community (Webster et al., 1997). It is evident therefore that predictions of risk have to consider historical, clinical and risk management items.

The following is a case study of a risk assessment using an assessment measure which considers background information, dynamic variables, and risk management factors, with a life-sentenced prisoner within the Scottish prison system.

Referral

A psychological risk assessment was requested by the Parole Board for Scotland to determine the level of risk of future violence that a life sentence prisoner (DA) would present if he was to be released from custody.

(a) Relevant background

DA was convicted of the murder of a male to whom he was previously unknown at the age of 17 years old. Has account is that he had assaulted the deceased when he

perceived a homosexual advance was made towards him. The victim later died in hospital as a result of a head injury. I reviewed DA's historical records in some detail and found no evidence of significant problematic behaviours throughout schooling. He had no offending history of note and his background had been otherwise unremarkable. I also noted that his family background appeared stable and he described his parents as supportive. I have provided a more comprehensive review of these background details as part of the risk assessment process (below).

I noted that DA had engaged in considerable offence related work to understand the antecedents of his behaviour as evidenced by his written submissions to the Parole Board. He was now considered by the Board to have reached the stage where he would be considered for parole.

(b) Behaviour at interview

DA presented at interview as a pleasant and co-operative man. He spoke at length in order to outline background events and his current circumstances. At other times he found some difficulty articulating his emotions. He was not clinically depressed or anxious during the interview. I could elicit no history of hallucinations or delusions and there was no evidence during the interview that he was experiencing thoughts or behaviour suggestive of a psychotic process. There were no indications throughout the assessment that he was being evasive in his responses. I gained the impression from the collateral information and consistency of DA's responses that he was open in his account to me.

Plan for assessment

There has been an increasing demand for psychologists to provide evidence based assessments of offenders to guide clinical practice and decision making (Macpherson, 1997; Thomas-Peter and Warren, 1998) and I considered it important to use a validated scale to inform clinical opinion when predicting DA's potential level of risk of violence on release from custody.

The Historical Clinical Risk-20 (HCR-20; Webster et al., 1997)

The Historical Clinical Risk-20 (HCR-20; Webster et al., 1997) is a violence risk assessment instrument with applicability to a variety of settings. The conceptual scheme of the HCR-20 considers contemporary opinion and recent research by considering risk factors as past, present, and future. The scheme includes ten historical factors which concern past behaviours and functioning, in addition to five clinical items which reflect dynamic (changeable) correlates of violence. Five risk management items also focus attention on post-assessment factors which may aggravate or mitigate risk of violence. The HCR-20 is an attempt to merge science and practice by offering an instrument that can be integrated into clinical practice but also is empirically based and testable.

Table 1. Risk factors of the HCR-20 (from Webster, et al., 1997)

Historical factors	Clinical factors	Risk management factors
H1 Previous violence	C1 Lack of insight	R1 Plans lack feasibility
H2 Age at first violent incident	C2 Negative attitudes	R2 Exposure to destabilisers
H3 Relationship instability	C3 Active symptoms of major mental illness	R3 Lack of personal support
H4 Employment problems	C4 Impulsivity	R4 Non-compliance with remediation attempts
H5 Substance use problems	C5 Unresponsive to treatment	R5 Stress
H6 Major mental illness		
H7 Psychopathy		
H8 Early maladjustment		
H9 Personality disorder		
H10 Prior supervision failure		

Risk of future violence

In assessing the risk for future violence with DA, I used the rationale of the Historical Clinical Risk-20 (Webster *et* al., 1997). The HCR-20 is neither a psychological test nor a 'profiling technique' but a special purpose risk assessment strategy that ensures relevant historical, clinical, and risk management items are considered by the clinician when conducting an assessment (Macpherson, 1997).

The items of the HCR-20 are based on acknowledged risk factors in the clinical and empirical literature that have proven predictive validity in forecasting future violence.

I reviewed the items of the HCR-20 with DA in some detail. I have also provided a brief rationale for each risk factor's inclusion in the HCR-20

Part A: Historical items

Contemporary research indicates that historical data should anchor risk assessments (Webster et al., 1997). There has long been a general consensus that it is necessary for clinicians to consider historical factors in determining future levels of risk (Monahan, 1981).

H1. Previous Violence

A history of previous violence is a strong predictor of an individual's propensity to engage in further acts of aggression (Monahan, 1981). The review of the literature by Klassen and O'Connor (1994) demonstrates that the probability of future crime increases with each prior criminal act

The level of violence used during the index offence represented a risk factor for violent recidivism. I noted however that DA had no previous convictions for assault or other violent offending and this reflected positively when determining any risk of future violence. There had been no recorded history of violence against staff or other prisoners throughout his years in custody.

H2. Young Age at First Violent Incident

A reliable finding in the clinical literature is the evidence to indicate that the younger the person is at the time of the first violent act, the greater the likelihood of subsequent violent conduct (Harris et al., 1993).

There was no evidence available to me to suggest any history of criminal violence prior to the index crime. However, DA's conviction for murder at the age of 17 years suggested a factor increasing the risk of future violent offending.

H3. Relationship Instability

It is recognised that the presence of social supports works to guard against violent crime (Klassen and O'Connor, 1994). Studies consistently demonstrate a correlation between relationship instability and violent behaviour (Harris et al., 1993).

DA's conviction and imprisonment at an early age prevented the development of a conventional relationship. I noted that he continued to remain in regular contact with his long-standing and supportive partner. He maintained a satisfactory relationship with his immediate and extended family and this reduced the level of risk of future violence.

H4. Employment Problems

General studies on recidivism show a link between unemployment and general criminal recidivism. Monahan (1981) suggested that unemployment is one of the strongest predictors for offenders engaging in future acts of violence

DA's conviction at an early age prevented him establishing a work history of note. I noted no significant problems during his education. His employment pattern within custody was not characterised by any difficulties and prison reports suggested that he was an industrious and competent worker. These factors reflected positively to reduce the risk of future violence.

H5. Substance Abuse Problems

There is a clear link between substance abuse and future violent conduct. In a range of studies on recidivism rates with offenders, a history of substance abuse predicted future violent behaviour more effectively than any other variable (Harris et al., 1993).

I considered his use of substances in a number of domains.

1. DA had a documented history of substance use within custody. His account was that he no longer used any illicit substances. I note that he used non-prescribed and illicit substances to problematic levels during his prison sentence. He had also consumed alcohol during a home visit.

2. DA was intoxicated at the time of the offence although I could elicit no indications of a history of alcohol dependence.

I formed the view that DA's use of opiates within custody and his use of alcohol while out of the prison establishment on a local licence reflected a propensity to renew substance misuse on release. I considered that DA's history of alcohol misuse would require to be monitored on release as alcohol and substances remained a risk factor for future violence.

H6. Major Mental Illness

The presence of a mental disorder as defined by standard diagnostic guidelines or nosological systems (DSM-IV, 1994) is a significant factor for the occurrence of violence. Schizophrenia and mania are noted as risk markers for future violence and the presence of a mental disorder in general increases the probability of lifetime violence (Monahan and Steadman, 1994).

I reviewed DA's psychological condition with him in some detail and formed the opinion that he did not have a history of a clinically significant psychological condition or exhibit historical evidence of a psychotic process. There was no previous history of low mood or self-harm. The absence of a mental disorder was a positive factor reducing the risk of future violence.

H7. Psychopathy

Numerous studies have demonstrated that the constellation of dysfunctional personality traits consistent with psychopathic personality disorder or 'Psychopathy' is the single most important consideration when completing an assessment of risk. Psychopathy is a robust risk factor for future violent offending (Hart et al., 1994).

The most systematic and psychometrically valid procedure currently available for assessing personality disorder is the Hare Psychopathy Checklist (PCL-R; Hare, 1991 and PCL-SV, Hart *et* al. 1995). The Psychopathy Checklist is known to be one of the best predictors of violence and has well-established reliability and validity (Hart, Hare, *et.* al, 1994).

The assessment procedure is based on a structured interview and a review of available collateral information. The scale consists of two main factors. Factor 1 centres on affective interpersonal traits and Factor 2 is comprised of behavioural traits. Psychopathy's defining characteristics such as impulsivity, criminal versatility, callousness and lack of empathy make the link between Psychopathy and violence straightforward (Webster, et al. 1997).

I used the Psychopathy Checklist: Screening Version (Hart et al, 1995) with DA and found that he scored well below the diagnostic cut-off for this type of personality disorder. This indicated that he did not exhibit a psychopathic personality. He did exhibit several traits including moderate levels of impulsivity and a history of

adolescent antisocial behaviour. I was confident however that the absence of such a personality disorder significantly reduced the risk of future violence on release.

H8. Early Maladjustment

Studies consistently find that early-identified difficulties at home, school, or in the community before the age of 17 correlates with violent behaviour. A history of childhood maladjustment through victimisation or through being a childhood victimiser or delinquent predicts adult violence (Harris, et al. 1993).

There was no evidence available to me to suggest a history of childhood victimisation. DA's account is that he engaged in delinquent behaviour during adolescence and appeared before the Children's Panel as a result of petty offending. His family background appeared to have been stable and there were no behavioural difficulties of note at home. The absence of a significant history of childhood maladjustment reduced the risk for future violence.

H9. Personality Disorder

There is some evidence of a predictive link between personality disorder and violence. Personality disorders of the antisocial or borderline type that conform to standard diagnostic criteria (DSM-IV, 1994) are over-represented in studies of murderers (Widiger and Trull, 1994). Antisocial personality disorder characterised by anger, impulsivity, and hostility elevates the risk for both general and violent criminal behaviour (Hare, 1991).

On reviewing DA's personality characteristics, I formed the opinion that he did not present with personality traits amounting to a personality disorder as recognised by DSM-IV. His prison behaviour suggested that he had tempered the most troublesome aspect of the immature personality evident during the initial years of his sentence. This was a positive indicator reducing the risk of future violence.

H10. Prior Supervision Failure

Serious supervision failures while an individual is on parole, probation or under the supervision of correctional or mental health agencies are associated with future violent acts (Harris, et al., 1993). Serious failure is concerned with re-offence or revocation of conditional release. Less serious failure is concerned with breaches of release conditions resulting in minor disciplinary actions. Prisoners with escape histories have a significantly elevated recidivism rate in comparison to those without escape histories (Bonta et al., 1996).

I noted that DA incurred a number of reports as a result of his poor attitude and insolence during the initial years of his sentence. There was no evidence of this behaviour in recent years. I also noted that he incurred several of breaches of discipline, most notably when he used alcohol on local licence, and was downgraded for opiate use. His failure to comply with conditions placed on his behaviour represented a moderate risk factor with regard to a future risk of violent recidivism

Part B: Clinical items

Historical items have the strongest support in terms of predictive acumen. There is some evidence however to suggest that clinical constructs may serve to moderate the effects of historical factors and may fluctuate over time. It is also acknowledged that clinicians can use clinical information to adjust level of risk since, in principal, dynamic factors are amenable to change (Munro & Macpherson, 1998). The following items have some support in the research literature as considerations when conducting risk assessment.

C1. Lack of Insight

The time-honoured clinical concept of 'lack of insight' is considered an important consideration in the risk assessment process. Insight is referred to as the reasonable understanding of one's own mental processes, reactions, and self-knowledge (Webster, et al., 1997). Failure to acknowledge levels of anger or dangerousness, or appreciate the consequences of mental disorder has obvious implications for an individual's self-control.

I gained that overall impression that DA was an increasingly insightful individual as regards his previous history, current situation, and overall functioning. This was a positive factor reducing the risk of violent recidivism

C2. Negative Attitudes

Clinical experience suggests that certain attitudes or sentiments may relate to violence. Andrews and Bonta (1995) suggest that anti-social attitudes towards individuals or institutions and pro-criminal sentiments may signal the presence of an increased propensity towards general or violent recidivism.

There were several indications of anti-social attitudes throughout the assessment including a perceived unfairness and anti-authority sentiments. I formed the view that he had tempered the most salient of these attitudes. This was a positive factor reducing the risk of violent recidivism

C3. Active Symptoms of Major Mental Illness

The presence of florid psychotic phenomena including thought disturbance, inappropriate affect, and hallucinations or delusions are noted by some researchers to be associated with the potential for violence (Monahan and Steadman, 1994).

There was no evidence to support this risk factor with DA.

C4. Impulsivity

The presence of behavioural and emotional instability with particular reference to anger and hostility in an individual's presentation and criminal history are of use in assessing risk of future violence (Webster et al., 1997). Impulsive individuals may over-react to real or imagined slights, insults or disappointments. This indicates a lack

of internal control over behaviour and influences levels of risk. Research has demonstrated that lifestyle impulsivity differentiates those offenders who recidivate from those who do not recidivate (Klassen and O'Connor, 1994).

I formed the view that DA's behaviour prior to custody and during the initial years of imprisonment had been characterised by impulsivity although this did not present as a salient feature of his behaviour in recent years. The aforementioned downgrade for alcohol use on local licence and a positive opiate test appeared to have been a catalyst for DA to reformulate his thinking and make a change to his behaviour. This was positive with regard to reducing the risk of violent recidivism.

C5. Unresponsive to treatment

Intervention designed to ameliorate psychological problems associated with criminal behaviour or compliance with education attempts to change criminogenic needs may be an important factor to consider in risk assessment.

There was no evidence at interview to indicate that DA would be unwilling to seek support or comply with the demands placed upon him. I note that DA completed several vocational courses within custody and expressed the view that he would comply with conditions or counselling on release. These were positive indications of a reduced potential for violence on release.

Part C: Risk Management Items

Risk management items centre on forecasting how individuals will adjust to future circumstances. The following items are considered by Webster et al (1997) to be important to the formation of appropriate risk management plans.

R1. Plans Lack Feasibility

An individual who has shown the ability to accept and make use of treatment programmes may be at reduced risk for violence. Intervention is dependent on available resources within the institution and depends to some extent on the individual's ability to seek resources and to be involved in future planning.

DA recognised that alcohol and substances may exert an influence over his behaviour on release. He was insightful enough to recognise that he may require relapse prevention and was willing to comply with any conditions placed on his alcohol use. This represented a positive indication of a reduced potential for violence on release.

I therefore recommended that he access an educational course on alcohol awareness within custody and follow this with supports on release into the community.

R2. Exposure to Destabilisers

Exposure to hazardous situations may trigger violent episodes. Destabilisers are referred to as the presence of weapons, substances, or victim groups (Webster, et al., 1997). In addition, Webster et al. (1997) have suggested that basic difficulties in

handling life skills such as housing and finances may increase the risk of acting violently. Clinical experience suggests that risk increases when individuals are discharged to those circumstances similar to the index offence.

I formed the view that the presence of a social support system provided by his family was a protective factor reducing the risk of future violence. DA had adequate employment prospects. On reviewing DA's background and future plans, I can find no significant destabilisers should he refrain from problematic alcohol use.

R3. Lack of Personal Support

Klassen and O'Connor (1993) found that poor family relations and a lack of emotional or financial support may be precipitating factor elevating the risk of future violence.

DA appeared to have an adequate support system. Prison reports indicated that he had the support of his partner and parents.

R4. Non-compliance with Remediation Attempts.

Individuals who lack the motivation to succeed, fail to comply with remediation attempts, or refuse to follow supervision are considered to be at risk of engaging in violent acts (Webster, et al., 1997).

DA appeared intent on making use of available resources on release. His recent positive attitude and behaviour within prison suggested a low probability of non-compliance with the conditions imposed upon him as part of his release.

R5. Stress

The stress that an individual may encounter and how he or she copes with this is an important point to consider in managing levels or risk of violence. It is noted that some individuals placed under stress may be likely to behave violently (Monahan, 1981).

I gained the overall impression that DA did not experience significant levels of stress and appeared to have developed a more mature coping ability with events during the past years in custody.

Summary risk rating

The basis of the assessment was to review the information available to me from the structured interview, review of collateral information, and assessment of historical, clinical, and risk factors associated with recidivism as outlined by the HCR-20. It was my overall clinical opinion, on the basis of historical, clinical, and risks management items, and the information available to me, that DA presented a low risk of violent recidivism.

I formed this view for two reasons. First, assessment of DA using the HCR-20 revealed few of the traditional historical risk factors for violent offending (for example, Antisocial Personality Disorder). There appeared to be no significant clinical risk factors or risk management concerns.

Second, the authors of the HCR-20 suggest that the measure can be scored actuarially (see Webster et al., 1997 for a full account of each risk factor and scoring). A score of 0 on any factor denotes the absence of that risk factor. A score of 1 denotes modest agreement with the intent of the risk factor. A score of 2 denotes that the criteria for the risk factor has been met in full. I therefore scored DA on the HCR-20 in order to provide empirical support to the above clinical opinion.

Table 2. DA's risk factor scores on the HCR-20

Historical	= 8	(minimum 0 maximum 20)
Clinical	= 1	(minimum 0 maximum 10)
Risk	= 1	(minimum 0 maximum 10)
Total HCR-20 Score	= 10/40	

In a post-dictive study of 40 offenders scored on the HCR-20, Strand et al. (1999) found that non-recidivists had a mean score of 22.39 (s.d. 6.85) and recidivists had a score of 30.77 (s.d. 7.22). Both groups were matched on demographic, clinical and criminal variables. Vincent (1998) made a similar finding in Canada with offenders

released from prison. DA scored significantly below the non-recidivist group in the study of Strand et al. (1999) and this placed him within the low risk of violent recidivism category according to Strand et al.'s (1999) research using the HCR-20.

I also made several recommendations to the Parole Board:

1. DA should attend an alcohol awareness programme in custody and continue this on release.

2. DA should have his use if alcohol monitored to assess whether he had established safe limits. I formed the view that his risk of recidivism would continue to decrease should he address any problems with alcohol.

3. The offer of employment was to be checked and confirmed to estimate whether this was a feasible option. I recommended that he should in addition be provided with a community based placement to ease the transition from institution to community.

4. DA's intentions to live with his partner should be assessed and the view of his partner sought in confidence to determine whether this was a feasible plan.

The Parole Board accepted that any plans for DA would have to be checked. They recommended to DA that he attend an alcohol education programme in addition to placing him on a community placement. He was reviewed one-year from submission of the psychological report and was recommended for release by the Parole Board.

Discussion

This case study demonstrates the clinical utility of the Historical Clinical Risk-20 (Webster, et al., 1997) for assessing risk for violence. The HCR-20 draws together historical, clinical, and risk management factors to allow predictions of risk of violent recidivism to be made on the basis of structured clinical judgment. It is no longer feasible to rely on subjective or impressionistic views when estimating risk, nor legally defensible should clinical judgment be subject to scrutiny in court.

The gold standard for evaluating any risk assessment measure is to conduct a long-term follow up of a large sample of offenders who are released into the community after being evaluated with the measure. The problem is that base rates of officially detected violent recidivism are low and may be as low as 30 per cent to 50 per cent over 25 years (Rice and Harris, 1997) and clinician's continue to be required to make predictions of risk. This case study demonstrates that the HCR-20 is a useful assessment tool with which to consider the concept of risk of violence and it is hoped that single case studies and larger scale research evaluations will continue to demonstrate the validity of structured clinical judgment. Schopp (1996) commented that *"an ideal system for communicating assessments of risk would provide clear, precise, and complete information"*. The HCR 20 is a useful measure which meets this requirement.

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Small Scale Research 1.

Development and use of the Compliance Interview Schedule

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List of Contents

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Introduction

Clinical experience and research evidence suggests the issue of 'compliance' to be a particularly relevant concern within an interrogative situation. Compliance is defined by Gudjonsson (1992) as:

> "the tendency of an individual to go along with propositions, requests or instructions for some immediate, instrumental gain" p 137.

Gudjonsson (1991) suggested that false confessions appear to be more related to compliance than interrogative suggestibility in cases of 'coerced-compliant' confessions. Compliance is also relevant for allegations during interview that an individual has been 'coerced' or exploited by others into criminal activity. While self-report scales exist to measure responses to questions relating to compliance (Gudjonsson, 1989), there are as yet no valid clinical construct rating scales measuring compliant behaviour across the lifespan.

The research literature suggests that differences can emerge between self-presentation at interview and questionnaire based methods (Tetlock and Manstead, 1985). Clinicians working in forensic settings cannot assume honest responding to self-report measures. There are reasons to suggest that the problems of response bias may be especially important in clinical-legal decision making or forensic evaluations (Hare *et al.* 1989; Hart *et al.* 1991, Hart *et al.* 1994).

Discrepancies between observed behaviour and self-report may cast doubt on results and weaken the integrity of the assessment (Rogers and Cavanaugh, 1983). Clinician rated measures must therefore be the preferred option for the clinician working within the forensic realm.

Gudjonsson (1989) suggested that measures based on observable behaviour have the advantage over self-report questionnaires because they control for self-report bias and faking. However, the Gudjonsson Compliance Scale (GCS) is a self-report measure as is the companion scale completed by a significant other. Cooke and Carlin (1998) commented that compliance is an important construct compromised by the transparency of the GCS for assessment purposes. There is a need therefore for a measure of compliance to be designed with the issues of self-report bias and assessment integrity in mind.

Purpose

The Compliance Interview Schedule (CIS) was designed as an interviewer rated behavioural schedule for the assessment of compliance. In developing the scale, key variables in the literature were isolated for their relationship with compliance. There is some disagreement in the literature over whether compliance should be viewed as a 'trait' or a 'state' (Gudjonsson, 1992). The Compliance Interview Schedule was designed to attempt to overcome this problem, since the focus of the scale is on interpersonal behaviour in general.

The scoring of the scale was made straightforward and sample questions were used with the intention of guiding the clinician's area of enquiry along a semi-structured interview format. The aim was to record data on these variables in a systematic and comprehensive way without inordinate length or complexity. It was not required that the assessor ask questions identical to those suggested in the guide as the clinician may wish to modify the interview in the light of relevant information. The addition of collateral information from clinical health records or background reports is an advantage.

Development of Items

A review of the clinical and research literature identified a number of characteristics relevant to the assessment of compliant behaviour. These were placed into three main factors: Behavioural characteristics, Lifestyle compliance, and Psychosocial adjustment.

Factor 1: Behavioural characteristics

Compliant individuals show certain behavioural characteristics in face-to-face interactions. They may avoid eye contact (Elsworth and Carlsmith, 1973). They are unlikely to interrupt (Zimmerman and West, 1975). Evidence suggests that a sex variable may operate in compliance. Females have been found to conform more than males under almost all conditions (Nord, 1969; 1971; Sistrunk and McDavid, 1971).

There has been some debate over whether a distinct compliant personality exists (Miller, 1995). It is assumed by a number of researchers that compliance is characterised by a collection of personality traits. These traits in combination with situational variables may make an individual go along with a request that they would not normally comply with. The evidence suggests that compliance is a stable characteristic (Gudjonsson, 1992). Recent research has identified compliant behaviour in children as young as 26 months (Konchanska *et al.* 1995a 1995b).

Deference to the opinion of others and a reluctance to speak out are indicators of compliance (McDavid and Sistrunk 1964) and relationship has been found to exist between compliance and a lack of assertiveness (Gudjonsson, 1992).

It could be reasoned that any interview situation is an anxiety-provoking situation for some. Individuals who do not cope well under pressure may behave more compliantly than those who can cope adequately with demands. Research evidence suggests that highly compliant individuals appear fully aware of their difficulties in coping with pressure (Gudjonsson, 1992).

Anxiety can be described as an unrealistic or excessive worry about various life circumstances. There should be evidence at interview of tension, apprehension, restlessness, difficulty concentrating and self-reported feelings of 'on edge' to score of this item. Anxious individuals are particularly so at times of stressful life events or crisis (Hawton *et al.* 1991). Feelings of anxiety related to guilt are a further

related and important factor increasing the likelihood of compliance (Gudjonsson, 1992).

Factor 2: Lifestyle compliance

School experience is important in assessing an individual's developmental history of compliance. Most individuals learn to comply with authority at an early age. Schooling involves interacting with authority figures. Truanting is *not* an example of non-compliance since this may be a way of avoiding conflict or people in authority.

The literature suggests conflict avoidance and avoidance coping to be a key construct underlying compliant behaviour (Gudjonsson, 1989). Fear of people in authority and confrontation is reported as contributing to compliant behaviour (Irving and Hilgendorf, 1980). Conflict avoidance refers essentially to the need to avoid conflict and confrontation particularly with people in authority. It may also be an attempt to avoid some form of punishment (Myers 1987; Saks and Krupat 1988).

Researchers have found that people who have a high need for social approval will be more yielding to social influence than those whose need is low. Need for social approval and low self-esteem form a cluster of traits resulting in a person being highly susceptible to social influence (Moeller and Appleweig 1957; Pennington 1986)

Factor 3: Psychosocial adjustment

Compliance has been defined as the process in which an individual accepts social influence in order to receive social or material rewards (Myers 1987; Saks and Krupat, 1988). It is known that compliant individuals will go along with requests in order to receive a social or material reward, or immediate instrumental gain (Gudjonsson, 1989). The person may be fully aware that their responses are being influenced, but nevertheless reacts in a compliant way.

Milgram's (1974) studies on obedience suggest that politeness and the desire to keep an initial promise may underlie compliant behaviour in specific situations. A main components underlying compliance is an eagerness to please (Konoske, Staple and Graf, 1979; Gudjonsson, 1989). Gudjonsson (1989) illustrated that the eagerness of a person to please is a valid factor in assessing compliance. Other researchers have found that deference to others, a tendency to avoid arguments, a reluctance to speak out, and a strong need for approval in social settings are indicative of compliant personality traits (McDavid and Sistrunk 1964). Crowne and Marlow (1960) stressed the importance of social desirability in relation to compliant behaviour.

An individual may allege that they have been forced into things, or 'coerced' or 'led' by a more forceful accomplice. This is particularly relevant if there is a previous criminal history. A general tendency towards compliance may make a person particularly susceptible to the exploitation by another. (Gudjonsson, 1989).

Kiesler and Kiesler (1970) suggest that compliant people will behave in a particular way without believing in what they are doing, that is, without private acceptance.

Social psychology literature suggests that compliant individuals express awareness of the difficulties in the company of authority figures. Prior experience (and reward for) submitting to authority may be apparent. Milgram (1974) suggests that an individual may feel as if they are being directed by someone else even though they are aware that what they are doing may be wrong (Willis and Levine, 1976). Gudjonsson (1989) has also found that fear and apprehension in the company of authority figures to be a key factor in compliance.

Compliance is found amongst prisoner groups that are not considered social conformists. Criminality was therefore not considered evidence of a lack of conformity. In the context of compliance, social conformity refers to the degree to which someone yields to pressures in general, irrespective of criminality. Asch (1955) suggests that avoiding conflict is a key element in complying with requests in order to maintain the status quo. Pleasing others is also thought to be more important than giving correct judgements (Pettigrew, 1958).

Development

Fourteen items associated with compliance were identified from the literature. A draft version of the CIS was prepared and reviewed by a professor of forensic psychology and a practising criminal defence lawyer. The items were subsequently re-assessed and redundant items removed. Items where there was a conceptual

overlap were combined into a more general factor. One item was dropped in the light of recent research. This resulted in a total of 10 items that formed the Compliance Interview Schedule (see appendix). The draft version contained a number of guide questions contained within a general background history interview.

Scoring

The scoring for the Compliance Interview Scale was on a 3-point ordinal scale based on the degree to which the individual fits the description of the item. This had proved an appropriate way of scoring items and ensuring reliability and validity in several contemporary forensic interview based clinician rated assessments (Hare, 1991; Kropp *et al.,* 1994).

2 A score of 2 implies that the a reasonably good match to the item in most respects. Behaviour should be generally consistent with that item.

1 A score of 1 is recorded when the item applies in some respects but that there are too many exceptions or doubts to warrant a score of 2.

0 A score of 0 is recorded when the item does not apply or the person does not exhibit the behaviour or characteristics intended in question.

Method

Nine subjects were included in the current study. The subjects were referred by criminal defence lawyers to the Forensic Clinical Psychology Department at the Douglas Inch Centre. The Douglas Inch Centre is a multi-disciplinary forensic outpatient clinic in Glasgow. All referral were made by criminal defence lawyers for psychological assessment. All subjects were male and were accused of criminal offences. Assessment was completed at the pre-trial stage and cases were rated on the Compliance Interview Scale at time of assessment.

In all cases results were obtained on the Gudjonsson Suggestibility Scale (GSS) and Gudjonsson Compliance Scale (GCS) (Gudjonsson 1997). Intellectual functioning was assessed using the Wechsler Adult Intelligence Scale – Revised (Wechsler, 1984) and was available on eight of the nine cases.

Results

Statistical analysis was performed using the Statistical Package for the Social Sciences (SPSS) to determine the strength of the relationship between the Compliance Interview Scale total score and factor scores, the Gudjonsson Suggestibility Scale (GSS) total suggestibility scores and factors scores, and the Wechsler Adult Intelligence Scale - Revised (WAIS-R) Full Scale scores, and Performance and Verbal IQ scores.

The first results show the mean and standard deviation scores for the Compliance Interview Scale for nine subjects.

Table 1. Means and standard deviations for the Compliance Interview Scale

Measure	Mean (n=9)	Standard deviation
Total CIS	9.67	4.36
F1: Behavioural Characteristics	4.56	2.19
F2: Lifestyle Compliance	2.11	1.83
F3: Psychosocial Adjustment	3.00	2.24

The second table shows the means and standard deviations for the Gudjonsson Suggestibility Scale total suggestibility scores and factor scores:

Table 2. Means and standard deviations for the Gudjonsson Suggestibility Scales

Measure	Mean (n=9)	Standard deviation
Total GSS	14.22	2.59
Yield 1	4.33	4.61
Yield 2	4.33	3.71
Shift	4.67	3.46

The third table shows the means and standard deviations for the Wechsler Adult Intelligence Scale – Revised, Full Scale scores, and Performance and Verbal IQ scores.

Table 3. Means and standard deviations for the WAIS-R

Measure	Mean (n=8)	Standard deviation
WAIS-R Full Scale IQ	80.25	6.61
WAIS-R Verbal IQ	80.63	7.60
WAIS-R Performance IQ	83.38	8.25

The fourth table shows the mean and standard deviation for the Gudjonsson Compliance Scale (GCS):

Table 4. Mean and standard deviation for the Gudjonsson Compliance Scale (GCS)

Measure	Mean (n=9)	Standard deviation
GCS	14.22	2.59

Table 5. shows the mean and standard deviations found in the current study compared to the means and standard deviations of a number of studies and populations assessed on the Gudjonsson Compliance Scale. The results are reported in the Gudjonsson Suggestibility Scales manual (Gudjonsson, 1997).

Table 5. Mean and standard deviation comparison on the Gudjonsson Compliance Scale between Gudjonsson (1997) and the current study

Measure	*n*	Mean	Standard deviation
GCS (current study)	9	14.22	2.59
GCS (Gudjonsson, 1997)			
Normal subjects	287	9.0	3.5
Alleged false confessors	192	14.3	4.0
Other forensic cases	83	11.1	4.5
Icelandic prisoners	343	9.6	3.3
Icelandic juveniles	108	8.9	3.2

Correlation coefficients were calculated to determine the relationship between the measures using Spearman's *rho*. Bryman and Cramer (1999) suggested that Spearman's *rho* is appropriate for non-parametric data and is a widely used statistical test to report research findings.

A statistically significant correlation was observed between the total Compliance Interview Scale score and the total Gudjonsson Compliance Scale score (r=.78, n=9, p=.013). Factor 1: Behavioural characteristics, and Factor 3: Psychosocial adjustment of the Compliance Interview Scale correlated with the Compliance Interview Scale total score (r=.76, n=9, p=.018) and (r=.94, n=9, p=.00) respectively. There were no significant relationships observed between Factor 2 of the Compliance Interview Scale: Lifestyle compliance, with the total Compliance Interview Scale score.

A significant correlation was observed between Factor 3: Psychosocial adjustment and Factor 1: Behavioural characteristics of the Compliance Interview Scale (r=.74, n=9, p=.022). No significant relationship was observed between Factor 1 or Factor 3 of the Compliance Interview Schedule with Factor 2: Lifestyle Compliance.

There were no statistically significant findings observed between the Compliance Interview Scale total or factor scores and the Wechsler Adult Intelligence Scale – Full Scale Score. There were no statistically significant findings observed between the Compliance Interview Scale and the WAIS-R Performance Scale or the WAIS-R Verbal Scale. A modest although not significant relationship was observed

between the Wechsler Adult Intelligence Scale - Full Scale score and Factor 2 of the Compliance Interview Scale – Lifestyle Compliance (r=.75, n=7, p=.051).

Factor 1 of the Compliance Interview Scale, Behavioural characteristics, correlated significantly with the Gudjonsson Suggestibility Scale total score (r=.72, n=9, p=.030). No significant relationship was observed between Factor 1 or Factor 3 with Factor 2: Lifestyle Compliance. There was no significant relationship between Shift on the Gudjonsson Suggestibility Scale and the Compliance Interview Scale.

Discussion

The central concept behind the current small research was to construct a scale to reliably assess compliant behaviour that did not rely on self-report or was so transparent that it may negate any findings. The method used to design the scale is similar to the methodology used to construct risk assessment measures employed by Kropp et al. (1994) and Webster et al. (1997) who identified the most commonly occurring factors in the research and clinical literature for risk of domestic assault and violence respectively, and collated these in a simple clinical construct risk assessment scheme.

The Compliance Interview Scale is intended to meet the practical considerations of clinicians evaluating the possibility of compliance during a Police interview or interrogative encounter where suggestions are made that an accused person has provided a false, self-incriminating account under duress. The Compliance Interview Scale may be used in addition to established psychometric tests such as the Gudjonsson Suggestibility Scales and has the advantage of being a clinical construct rating scale rather than a self-report measure. Gudjonsson (1989) observed that behavioural measures have the advantage over self-report questionnaires because they control for self-report bias and faking.

The significant correlation observed between the total Compliance Interview Scale and the Gudjonsson Compliance Scale total scores tentatively suggests that the two measures are conceptually related and may measures the same underlying factor.

Further research using a larger sample of subjects and a normal population of subjects may determine whether this is a more general finding.

Cooke and Carlin (1998) reviewed the Gudjonsson Suggestibility Scales and suggested that compliance rather than suggestibility was the primary factor determining a false confession. This fits with clinical experience - few accused persons begin to believe or internalise that they have committed an offence – the vast majority of individuals who allege that they provided a false, self incriminating statement, state that they did so under inducement or as a consequence of interpersonal pressure applied during Police questioning. The current research did not find a relationship between factors of the Compliance Interview Schedule and the Gudjonsson Suggestibility Scale total scores or factor scores. There was no significant correlation observed between the total Compliance Interview Scale scores or factor scores with Shift on the Gudjonsson Suggestibility Scale. This is a rather disappointing finding in the light of Gudjonsson's early research (1989) which found a significant correlation between the Gudjonsson Compliance Scale and 'Shift' on the Gudjonsson Suggestibility Scale.

Gudjonsson (1989) found that suggestibility and compliance are, at a conceptual level overlapping characteristics that share similar mediating variables. There was no significant relationship between the Compliance Interview Scale and the Full Scale WAIS-R. This is consistent with the research of Gudjonsson (1989) who found that his self-report measure of compliance, the Gudjonsson Compliance Scale, was not associated with low intellectual functioning. It is notable that

Gudjonsson (1997) suggests that his Compliance Scale should not be used with individuals of intellectual functioning of 69 and below. As low intellectual functioning is significantly correlated with Suggestibility, it may be useful to attempt to validate the Compliance Interview Scale with a population of learning disabled individuals to assess whether the scale is a useful measure in circumstances where use of the Gudjonsson Compliance Scale is inappropriate. This is feasible using the Compliance Interview Scale as the requirement for literacy is removed because the measure is rated by the clinician.

The results suggest that the Compliance Interview Scale might be an additional measure to use when assessing the reliability or unreliability of a self-incriminating confession that has subsequently been retracted. As Gudjonsson (1997) observed:

> "Unlike suggestibility, compliance is difficult to measure behaviourally in a forensic setting, because the person would have to be requested to take part in a task that is often cumbersome and difficult to control outside a laboratory setting".

The definition of compliance provided by Gudjonsson (1992) emphasises the readiness of an individual to *go along with propositions or requests for some instrumental gain*, particularly during an interrogative situation. There may remain other explanations for complaint responding. The influence of 'social conformity' (Pettigrew, 1958) or 'social desirability' (Crowne and Marlow, 1960), particularly in response to authority, may provide competing explanations for complaint behaviour. The possibility that compliance is simply a measure of lack of

assertiveness is a further consideration not addressed by the Gudjonsson Compliance Scale. Gudjonsson (1992) also suggested that compliance is more of a personality trait than a cognitive measure. However, there remains a healthy debate over whether a distinct compliant personality exists, or whether behaviour is more readily understood within the interpersonal context in which compliant responding occurs (Miller, 1995). The restricted focus of the Gudjonsson Compliance Scale to situations of pressure may limit an understanding of an individual's behaviour in more general interpersonal situations.

Gudjonsson (1992) suggested that many items of the Gudjonsson Compliance Scale give a fair indication of what the scale is measuring and some individuals may endorse the scale in such as way as to exaggerate their compliance scores and observed that testing compliance by any means other than self-report, or encouraging individuals to perform in ways they may not wish to, may raise questions regarding ethics.

The Compliance Interview Scale is presented as a clinical construct rating scale that may be used to assess compliant behaviour via presentation at interview and life history of compliance. The measure is not intended to assess whether the account of an accused person is invalid, but is intended to form part of the overall assessment during which an alleged false admission has been made.

The Compliance Interview Scale may also be viewed as a return to the work of Milgram (1974) whose experiments to assess compliance were based on

observation rather than self-report. With ethical considerations in mind, and in view of several of the positive findings to date using the Compliance Interview Scale, further research with a larger sample may be appropriate.

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Compliance Interview Scale

Name:.....Date of assessment.....

Factor 1: Behavioural characteristics

Item 1: Compliant Behaviour at Interview	No	Maybe	Yes
	0	1	2

Item 2: Anxiety	No	Maybe	Yes
	0	1	2

Item 3: Lack of Assertiveness	No	Maybe	Yes
	0	1	2

Item 4: Low self-esteem	No	Maybe	Yes
	0	1	2

Factor 2: Childhood & Adolescent Compliance

Item 5: Childhood & Adolescent Compliance	No	Maybe	Yes
	0	1	2

Item 6: School Compliance	No	Maybe	Yes
	0	1	2

Factor 3: Psychosocial adjustment

Item 7: Conflict Avoidance	No	Maybe	Yes
	0	1	2

Item 8: Eagerness to please	No	Maybe	Yes
	0	1	2

Item 9: Poor Coping with Pressure	No	Maybe	Yes
	0	1	2

Item 10: High Social Conformity	No	Maybe	Yes
	0	1	2

Total Compliance Interview Score	

Subject

Measure	1	2	3	4	5	6	7	8	9
CIS Total	12	7	14	8	13	3	16	5	9
CIS Factor 1: Behaviour	7	2	8	3	5	2	5	3	6
CIS Factor 2: Lifestyle	1	4	1	4	4	1	4	0	0
CIS Factor 3: Psychosocial	4	1	5	1	4	0	7	2	3
WAIS FS IQ WAIS VIQ WAIS PIQ	76 79 75	80 79 88	n/a	82 78 93	84 82 92	82 82 87	91 97 87	78 78 83	68 70 69
GCS	17	11	17	14	13	13	16	11	14
GSS Yield 1	1	3	1	5	1	5	8	3	2
GSS Yield 2	0	3	0	5	1	7	7	5	11
GSS Shift	1	5	2	3	0	8	8	3	10
GSS Total	2	8	3	8	1	13	16	6	12

The Gudjonsson Suggestibility Scales

Gisli H. Gudjonsson

THE GUDJONSSON COMPLIANCE SCALE (GCS) FORM D

Test Record Form and Scoring Sheet

Subject name:		**Reference number:**
Age:	**Sex: M / F**	**Occupation:**
Test date:		**Test administrator:**
Notes:		

Additional test record forms and scoring sheets may be obtained from Afterhurst Mail Order Services, 27 Church Road, Hove, East Sussex BN3 2FA, UK. Fax: (+44) (0)1273 722180.

ISBN: 0-86377-446-6

Psychology Press
27 Church Road
Hove
East Sussex BN3 2FA

THE GCS (Form D)

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is *true* or *false* as it applies to you personally. If the statement is true as applied to you then circle "T"; if it is false as applied to you then circle "F"

1.	As a child I always did as my parents told me.	T	F
2.	I give in easily when I am pressured.	T	F
3.	I am not too concerned what people think of me.	T	F
4.	I tend to become easily alarmed and frightened when in the company of people in authority.	T	F
5.	When I was a child I sometimes took the blame for things I had not done.	T	F
6.	When I am uncertain about things I tend to accept what people tell me.	T	F
7.	I tend to go along with what people tell me even when I know that they are wrong.	T	F
8.	I would describe myself as a very obedient person.	T	F
9.	I would never go along with what people tell me in order to please them.	T	F
10.	I find it very difficult to tell people when I disagree with them.	T	F
11.	I tend to give in to people who insist that they are right.	T	F
12.	I try very hard not to offend people in authority.	T	F
13.	I strongly resist being pressured to do things I don't want to do.	T	F
14.	I generally tend to avoid confrontation with people.	T	F
15.	I try to please others.	T	F
16.	People in authority make me feel uncomfortable and uneasy.	T	F
17.	I try hard to do what is expected of me.	T	F
18.	Disagreeing with people often takes more time than it is worth.	T	F
19.	I generally believe in doing as I am told.	T	F
20.	I believe in avoiding rather than facing demanding situations.	T	F

The Gudjonsson Suggestibility Scales (GSS)

Gisli H. Gudjonsson

THE GSS 2

Test Record Form and Scoring Sheets

Subject name:		**Reference number:**
Age:	**Sex: M / F**	**Occupation:**
Test date:	**Start times**	
		(a) Immediate recall start time:
		(b) Delayed recall start time:
		(c) Questioning start time:
Test administrator:		**Also present:**
Notes:		

Additional test record forms and scoring sheets may be obtained from Afterhurst Mail Order Service, 27 Church Road, Hove, East Sussex BN3 2FA, UK. Fax: (+44) (0)1273 722180.

ISBN: 0-86377-446-6

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Hove
East Sussex BN3 2FA

IMMEDIATE RECALL ON THE GSS 2

Anna and John/ were a happily married couple/ in their thirties./ They had three children,/ two boys/ and a girl./ They lived in a small bungalow/ which had a swimming pool/ in the garden./ John worked in a bank/ and Anna worked in a bookshop/ with her sister/ Maria./ One Tuesday/ morning/ in July/ the couple were leaving the house/ to go to work/ when they saw a small boy/ going down a steep slope/ on a bicycle/ and calling for help./ Anna and John ran after the boy/ and John caught hold of the bicycle/ and brought it to a halt./ The boy appeared very frightened/ but unhurt/ and said that the brakes on his bicycle had broken./ Anna and John recognised the boy,/ whose name was William./ He was the youngest/ son of their neighbours/ who worked for a well-known/ travel agency/ in a nearby town./ Sometimes in the winter months/ the two couples had gone skiing together/ but the children of both families/ had preferred to stay with their grandparents/ who lived in the country./

SCORES		
Memory recall	=	(max. 40)
Distortions	=	(D1)
Fabrications	=	(F1)
Total Confabulations*	=	(TC1)

*The total of D1 + F1.

TEST ADMINISTRATOR'S NOTES

DELAYED RECALL ON THE GSS 2

Anna and John/ were a happily married couple/ in their thirties./ They had three children,/ two boys/ and a girl./ They lived in a small bungalow/ which had a swimming pool/ in the garden./ John worked in a bank/ and Anna worked in a bookshop/ with her sister/ Maria./ One Tuesday/ morning/ in July/ the couple were leaving the house/ to go to work/ when they saw a small boy/ going down a steep slope/ on a bicycle/ and calling for help./ Anna and John ran after the boy/ and John caught hold of the bicycle/ and brought it to a halt./ The boy appeared very frightened/ but unhurt/ and said that the brakes on his bicycle had broken./ Anna and John recognised the boy,/ whose name was William./ He was the youngest/ son of their neighbours/ who worked for a well-known/ travel agency/ in a nearby town./ Sometimes in the winter months/ the two couples had gone skiing together/ but the children of both families/ had preferred to stay with their grandparents/ who lived in the country./

SCORES		
Memory recall	=	(max. 40)
Distortions	=	(D2)
Fabrications	=	(F2)
Total Confabulations*	=	(TC2)

*The total of D2 + F2.

TEST ADMINISTRATOR'S NOTES

GSS 2 SCORING SHEET

Questions		*Yielded to 1 (#)*	*Answers Yield 1*	*Yielded to 2 (#)*	*Answers Yield 2*	*Shift (S)*
1.	*Were the couple called Anna and John?*					
2.	Did the couple have a dog or a cat?					
3.	Did the boy's bicycle get damaged when it fell on the ground?					
4.	Was the husband a bank director?					
5.	*Did the couple live in a small bungalow?*					
6.	Did the boy on the bicycle pass a stop sign or traffic lights?					
7.	Was the boy frightened of the big van coming up the hill?					
8.	Did the boy have some minor bruises as a result of the accident?					
9.	*Was the boy's name William?*					
10.	Did the boy drop the books he had been carrying whilst riding the bicycle?					
11.	Was Anna worried that the boy might be injured?					
12.	Did John grab the boy's arm or shoulder?					
13.	*Did the couple recognise the boy?*					
14.	Did the boy commonly ride the bicycle to school?					
15.	Was the boy taken home by Anna or John?					
16.	Was the boy allowed to stay away from school on the day of the accident?					
17.	*Did the couple's children sometimes stay with their grandparents?*					
18.	Was the boy frightened of riding the bicycle again?					
19.	Was the weather wet or dry when the accident happened?					
20.	Did the couple have a skiing cottage in the mountains?					

SCORES		
Yield 1	=	(max. 15)
Yield 2	=	(max. 15)
Shift	=	(max. 20)
Total Suggestibility*	=	(max. 35)

*The total of Yield 1 + Shift.

NON-STANDARD RESPONSES

=

=

=

=

Small Scale Research 2.

Anger Management Fast-Track: a descriptive account of a waiting list initiative utilising a large group format.

Gary J D Macpherson

Submitted in part fulfilment of the degree of doctorate in Clinical Psychology at the University of Edinburgh

List of Contents

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Introduction

There is an ever-increasing pressure on mental health services and a need to confront the issue of cost effectiveness in service delivery, particularly for psychologists working in poorly resourced and overburdened settings. Within the NHS, time between referral and first appointment to access clinical psychology primary care services is frequently over six months, while a significant minority of patients wait over one year for an initial appointment.

It has long been suggested that psychologists should improve their ability to develop new therapeutic approaches relevant to problems presenting in primary care (Johnston, 1978). A number of innovations have been applied to manage waiting list demands, including (i) 'two-plus-one' sessions - where an initial assessment appointment is followed by two interventions sessions, (ii) 'prescriptive assessment clinics' - where advice and intervention are offered during the initial appointment, and (iii) 'while you wait' approaches – where educational material is provided to the patient by post during time spent waiting for assessment (Barkham and Shapiro, 1989; Denner and Reeves, 1994; Murray and Walker, 1996).

This small-scale research study outlines a descriptive account of the development and application of an innovative outpatient forensic mental health service: Anger Management Fast-Track (AMFT). The study outlines in brief a review of traditional service delivery within large group format primary care services. Second, the study describes the development of traditional anger management

services and the requirement for a 'fast-track' anger management service. Finally, the benefits and problems encountered of applying AMFT with forensic outpatients are discussed.

Traditional service delivery

Most out-patient primary care services now offer some form of group treatment based on educating a patient on cognitive and behavioural principles (White, 1995). The growth of group educational approaches is both clinically warranted and a function of managing demand for services. Clinically, group formats are shown to be effective in tackling primary care patients' clinical needs both in the immediate and longer term (Omrod, 1995). Service delivery may also become more efficient by maximising clinical time and reducing waiting lists.

White (1997) has discussed both practical and clinical reasons why an educational approach to a clinical problem in primary care can be of benefit to the patient:

- 'demystify' the clinical problem;
- cultivate appropriate expectations regarding control rather than cure;
- achieve a sense of control in areas they perceive to be lacking;
- encourage responsibility by providing a structured way of thinking about clinical problems and generate an attitude shift towards problem resolution;
- involve family and friends in the treatment

Anger Management

The Douglas Inch Centre is a multi-professional forensic mental health outpatient facility in the centre of Glasgow. Referral to the Douglas Inch Centre are from a variety of sources including the Sheriff and District Court, Social Work Departments and mental health services throughout Primary Care Services across Greater Glasgow NHS Trust. Requests for anger management are amongst the most common referral to the Forensic Clinical Psychology service and demand typically outweighs the ability to provide clinical psychological intervention. In order to meet the demands of patients within existing resources, an innovative approach was required to timeously and effectively address clinical needs while managing the number of referrals and supplementing the existing service.

Although there is variability in the content and delivery of traditional anger management, many programmes are based on the most comprehensive model of 'stress inoculation' outlined by Novaco (1977). Typical anger management aims to teach patients how to:

- monitor bouts of anger
- observe the relationship between cognitions and environmental events
- control the experience of anger when it arises

Novaco (1994) suggested that psychological intervention should consist of three stages:

1. Cognitive preparation - an educational phase where the patient learns about the nature of anger and the rationale for intervention. Information is given about the difference between anger and aggression and the factors contributing to anger escalation. Patients are taught to use an anger diary and to construct an anger hierarchy of provocative situations.

2. Skill-building - in this stage, the patient learns ways of coping with thoughts and feelings, for example, arousal reduction strategies, communication skills, and cognitive restructuring.

3. Application Practice - the first two stages are then combined initially using role-play scenarios based on the patient's hierarchy of real situations to allow practice of skills. The patient is then encouraged to select real situations in which to practice these skills.

Anger management begins with a standard individualised assessment to pinpoint the patient's need for anger management, educate the patient about the nature of anger, and encourage them to assess their own responses to anger.

The majority of research to date has examined anger amongst patients detained in secure settings (Ramm *et al* 2000). Novaco (1994) found a significant relationship between self-reported level of anger and violent crime in a retrospective study of

patients detained within the California State Hospitals. Kay *et al* (1988) found anger to be the biggest predictor of physical aggression in the diagnostic profiles of 208 psychiatric in-patients.

Despite such evidence the management of anger continues to be an area neglected in the research. Several small group treatments have been reported although these are confined to secure or institutional settings (McDougall, 1987; Hughes, 1996). Renwick *et al* (1997) demonstrated the efficacy of anger management with four patients at the State Hospital, Carstairs. However there exist no studies relating to outpatient anger management and this may be a result of a variety of problems.

Problems delivering traditional anger management in outpatient settings

Forensic patients often lead chaotic lifestyles and this may be reflected by difficulties attending sessions. They may exhibit co-morbidity such as alcohol and/or drug problems and may be more likely than other NHS patients to fall foul of the law whilst on waiting lists, thus finding themselves within the criminal justice system rather than a mental health setting. Clinical experience suggests that many patients who attend clinical psychology services exhibit erroneous assumptions regarding the nature of psychological treatment. Anger management patients in particular do not differ in this regard: most patients do not expect to be asked to keep a record of their behaviour or to practice techniques between

sessions. The combination of these factors may have an impact on attendance and attrition rates to forensic mental health outpatient services in general.

Anger Management Fast Track

Anger Management Fast Track (AMFT) was developed for three reasons. The first reason was an attempt to manage more effectively a waiting list at the Douglas Inch Centre of ten months for individual anger management. The second reason was to more fully inform patients' expectations of clinical psychological intervention within an NHS forensic outpatient clinic. The third reason was to begin to identify maladaptive behaviour patterns associated with anger and introduce alternative approaches to anger management.

Process

A clinical psychologist who acts as AMFT co-ordinator screens referrals to determine suitability for anger management. Suitability is based on a primary clinical problem of poor anger control rather than substance dependence or personality disorder impacting on management of behaviour. A letter is sent to the source of referral stating that the patient will be offered a place on the next available AMFT group session. Brief details concerning the content of the two sessions are sent to the referrer who is invited to contact the Forensic Clinical Psychology department if there are known contra-indications to offering the approach. Potential conflicts include illiteracy, social phobia, paranoia and certain physical disabilities.

Thirty patients were invited to attend each session and the duration of each session was one hour. Patients with alcohol and drug difficulties secondary to problems with anger management were not excluded from the service, as attention is drawn within the AMFT sessions to the compromising effects of substances over the control of anger.

Measures

Patients attending for AMFT were asked to complete several self-report assessment measures during the two sessions. The Novaco Anger Scale (NAS; Novaco, 1994) was used in an attempt to assess cognitive, arousal, and behavioural domains of anger in two parts. Part A contains clinically orientated scales and part B provides an index of anger intensity and generality across a range of potentially provocative situations (Novaco, 1994).

The NAS was developed and validated for use with mentally disordered as well as normal populations in conjunction with the Violence Risk project of the Macarthur Foundation Research Network on Mental Health and the Law. In studies with psychiatric patients in California State Hospitals (Novaco, 1994) the NAS was found to have an internal reliability of .95 and a test-retest reliability (two weeks) of .84. The author recently revised the NAS and the NAS Part B has since been designated as the Provocation Inventory (NAS-PI: Novaco *in press*).

The NAS was offered to patients to complete at the start of the first AMFT session and was intended to be used to determine change in a patient's experience of anger following completion of any subsequent post-AMFT individual anger management.

The Barratt Impulsiveness Scale-11 (BIS-11; Patton *et al* 1995) was also offered to patients to complete at the beginning of session one to assess patients' cognitive style, planning, and coping ability. Impulsivity is considered to be an important determinant of violence in offenders in that deficits relate to the control or self-regulation of behaviour, i.e., poor behavioural inhibition (Barratt, 1994). Impulsivity has been viewed as either an inability to be reflective or the interval between a particular event and the individual's response. Aggression has been linked to impulsiveness across various domains: motor (i.e. acting without thinking); cognitive (i.e. making quick decisions); and non-planning (i.e. unconcern for consequences).

Fossati *et al* (2001) found the BIS-11 to have an internal consistency of .79 and a two-month test-retest reliability of .89. Impulsivity is recognised in the research literature as related to 'impulsive aggression' and a self-reported inability to control aggressive behaviours. Overall completion rates for the NAS and BIS were poor in view of time taken to complete the measures and late-coming to the session.

Several brief rating scales developed at the Douglas Inch Centre were used during the sessions. These included measures to evaluate the patient's knowledge of anger consisting of a number of true-false questions completed at the beginning of session one and at the end of session two when the patient has the opportunity to 'opt-in'

for individual anger management sessions. The form was designed to have a high pass rate even on first completion to suggest to the patient that they already posses a reasonable understanding of anger and that they simply require to manage the experience more effectively. Measures are also used to rate various aspects of the video presentation in terms of the passivity, assertiveness, or aggressiveness of the actor in the video role-play.

The questionnaires were used for three reasons. First, they may act as a focus for the patients to identify their pattern of anger including impulsive cognitions and behavioural response. Second, they offered the potential of a baseline to assess clinical change in patients who subsequently opt for anger management on an individual basis following the AMFT sessions. Third, psychometric measures may play a useful role in any subsequent individual treatment programme by raising treatment issues with the clinician (Milne and Dawson, 1997).

Session one

The clinical psychologists attached to the psychology department presented the two AMFT sessions on a rotational basis. In order to reduce the likelihood of inattention or boredom, the didactic presentation was interspersed with the completion of self-report measures or paper and pencil exercises. During the first session, patients were advised of the rules that operate within the group, for example refraining from comment or leaving questions to the end of the session. This was considered a necessary stage in order to set expectancies of the session and ensured consistency between sessions.

The first session described the normality of anger, the positive and negative functions of anger, and the aim of anger management. Novaco and Welsh (1989) suggested that the adaptive and self-justifying aspects of anger must be acknowledged before proceeding with stress inoculation, where patients are encouraged to identify their maladaptive behavioural patterns. The emphasis is on effective anger management rather than cure: recognising the emergence of anger early in its generation and exploring the use of adaptive strategies to control the anger.

A simple model of anger was then presented to increase insight into the cognitive, arousal and behavioural aspects of the experience of anger. Finally, patients were shown how to monitor their behavioural patterns using an anger diary and complete this for the following session. A friend or relative was also encouraged to complete a brief rating scale regarding their observations of the expression of the patient's anger. An information leaflet was provided for all patients to summarise the important points made during session one.

Session two

The second session, also lasting one-hour, described adaptive and maladaptive coping responses, and the role of alcohol and drugs as potential disinhibitors on the control of behaviour. Patients were encouraged to compare their own diary from the previous week with an example of a standard completed diary. The possible

emergence of anger patterns at particular times of day, in response to a significant other, or a particular situation, was reviewed in some detail.

A series of videotaped role-plays was viewed, showing one common situation handled in three contrasting ways. An actor is seen dealing with an interpersonal situation in a passive, aggressive, and assertive way. The rationale for this section is the work of Novaco (1978) who emphasised the reciprocal relationship between the *perception* of a provocative situation and an increase in anger arousal. The emphasis is on the importance of an assertive style of communication rather than a display of aggression and poor problem solving. Patients were encouraged to identify and record the adaptive and maladaptive behaviours shown within the video and common explanations of these were explained by the clinician. The use of progressive muscular relaxation to decrease anger arousal was explained in conjunction with helpful and unhelpful strategies for anger control. The key points of the two sessions were then summarised. Finally an evaluation form was completed and patients were encouraged to select whether they wish to attend for individual assessment and follow-up intervention.

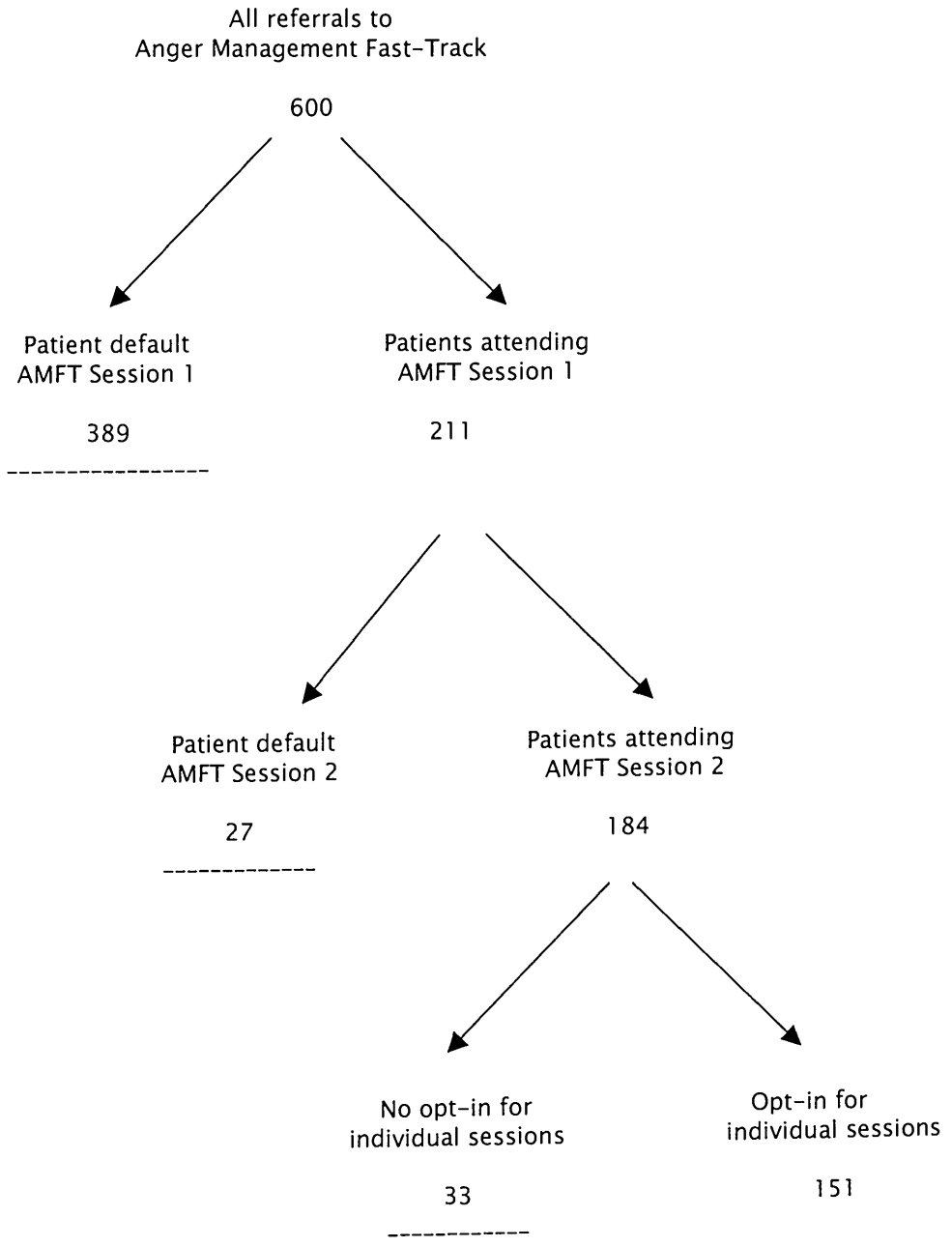
Results

The first results are a descriptive account of attendance rates, attrition, and patient opt-in for AMFT referrals to the Douglas Inch Centre between October 1997 and July 1999.

(a) Attendance rates

Twenty two-session AMFT groups were completed between October 1997 and July 1999. A total of 211 outpatients attended from 600 referrals since the sessions began. This represents an initial attendance rate of 35.2% for the first session with a drop in patient numbers for attendance on the second session. Attendance and attrition rates are shown in fig 1. (below)

Figure 1. Patient referral to AMFT Service and opt-in numbers for individual anger management.



(b) Patient opt-in

A total of 184 patients attended the second session. One hundred and fifty one patients opted to complete individual anger management following completion of session two. The total number of patients' opting-in for individual anger management represented only 25.2 per cent of the total number of referrals.

(c). Attrition rates

One of the most noticeable features of the AMFT Service was the number of patients who defaulted from initial attendance and the number of patients who failed to complete the two-session AMFT programme or attend for individual anger management. Attrition rates are outlined in figure 2 (below).

Fig. 2. Attendance and attrition rates as a percentage of all referrals

Number of referrals	Percentage of attenders	Percentage of defaulters
Total referrals	100%	-
Attend AMFT Session 1	35.2%	64.8%
Attend AMFT Session 2	30.6%	69.4%
Attend individual anger management	25.2%	74.8%

Preliminary data was gathered on several of the measures used in the study although the limited completion rate and small sample size suggests that any meaningful conclusions may be difficult to establish.

Of interest are the scores on the Barratt Impulsiveness Scale-11 (BIS-11; Patton *et al* 1995) obtained from AMFT patients. Completed BIS-11 questionnaires were obtained from 69 patients attending the AMFT and the AMFT sample is compared to existing samples are presented in Table 2. (below).

Table 1: Comparison of BIS scores for AMFT patients and other samples Fossati *et al* (2001)

Sample	*n*	BIS Total	sd
College students (Italian) Fossati *et al* (2001)	763	64.11	10.07
College students (US) Patton *et al* (1995)	409	63.82	10.17
AMFT patients	69	67.29	16.86

Novaco Anger Scale (NAS) results were available for a total of 65 patients who attended the first session of the AMFT programme and for whom completed measures were available. Results are compared to existing normative data for other samples provided by Novaco (NAS-PI *in press*) as presented in Table 2 (below).

Table 2. Comparison of AMFT NAS scores and existing Novaco Anger Scale norms from the NAS-PI

Sample	n	Total Part A	sd	Total Part B	sd
California State Hospital Patients (USA)	158[1]	90.1	18.2	65.3	17.5
Carstairs State Hospital (Scotland)	119	82.5	18.8	56.6	16.5
St Andrews Psychiatric Hospital (England)	80	95.8	12.3	65.3	12.3
Hawaii Vietnam Vets project (USA)	73	114.5	15.3	78.1	14.1
Millhaven Institution general psychiatric admissions (Canada)	102	80.4	15.8	53.0	15.8
University of California undergraduates - Spring 1993 (USA)	159	82.6	13.5	63.9	11.7
Sinburne University (Australia)	215	81.7	12.2	60.9	12.9
AMFT Service	65	41.67	7.74	43.7	7.08

[1] data taken from 3 hospitals

Discussion

Two problems are apparent from this type of large group didactic service delivery. First, the quality of information accompanying a referral is important. Letters from referral agencies often fail to include information relevant to performance within the group, such as a patient's difficulties with literacy or the potential for anxiety within a large-group setting. This was addressed by offering guidance by telephone to referral agencies on inclusion and exclusion criteria. In addition, the co-ordinator for the screening and delivery of AMFT reinforces the suitability criteria when responding to a referral deemed inappropriate (for example, co-morbid alcohol dependence).

A second problem for large group service delivery is the potential for intoxicated patients to disrupt the group or place the safety of others at risk. Although this problem is not exclusive to an anger management patient population, the early detection of this problem in the group is desirable in order that appropriate risk management steps can be taken. The reception staff have the opportunity to report to the psychologist whether a patient may be intoxicated at time of arrival at the clinic and the patient can be seen individually to assess the situation prior to the AMFT session.

Only one quarter of all patients referred to the service eventually opt-in for individual anger management - almost 65 per cent of all referrals to AMFT fail to attend session one of the programme and almost three-quarters of all initial referrals do not proceed to individual anger management. There may be several possible

explanations for the high rate of non-attendance. First, the patient may be unable to attend for reasons relating to the request for anger management (for example, Court proceedings or prison custody as a result of violence) or for other reasons (change of address). Second, patients may not identify anger as a primary problem. Third, anger management problems may be associated with other clinical issues (for example, alcohol dependence, depression) and these may have been addressed prior to the offer of attendance on AMFT. Further research is required to establish the reasons for non-attendance and attrition rates to determine whether an alternative service or approach may optimise patient needs.

In addition to the poor attendance and high attrition rates from the AMFT programme there was also the failure of patients to complete the measures during the AMFT sessions. This may have reflected late coming to the sessions or unwillingness to complete the measures - in retrospect an attempt should have been made to gauge patient's views on completing the measures.

In relation to the Barratt Impulsiveness Scale Scale, Barratt (1994) suggested that impulsiveness is significantly related to 'impulsive aggression', which involves an inability to control aggressive behaviour. The present results suggest that AMFT patients exhibit comparable levels of impulsivity to the respective samples of Italian undergraduates and North American undergraduates. The standard deviation may suggests a higher degree of variance between scores on the BIS-11 for the AMFT patients than the Italian and US students - there are problems however interpreting the data due to the sample size and the comparison of a clinical sample a non-clinical sample of undergraduates – and the limited completion rate may

mean that any conclusions are difficult to establish. The lack of published data relating to clinical populations and scores on the BIS-11 may hinder any meaningful conclusions in this research. The sample of AMFT patients who completed the BIS-11 in this research may be biased and may represent only those who took time to complete the measure - the hypothesis being that the results represent the *least* impulsive patients – although any firm conclusions may only be made from a more representative sample of patients.

With respect to the Novaco Anger Scale, one observation is the low scores on Part A of the NAS for AMFT patients in comparison to the non-clinical samples reported by Novaco – the AMFT NAS Part A score is lower than all the reported clinical and non-clinical samples. The mean score for Part B of the NAS is also lower than all the comparison samples. The results are again difficult to interpret meaningfully for the reasons stated above and due to the relatively small number of AMFT patients who completed the Novaco Anger Scales (only 30.8% of the total patients attending AMFT Session 1 completed the measure) although the tentative conclusion is that AMFT patients exhibit an lower overall experience of anger on a variety of anger domains than existing clinical and non-clinical samples - further research is required with a larger sample size and more representative sample.

Anger management fast-track highlights the issue raised by White (1998), that psychologists should be utilising our talent in innovation to deal with the ever-increasing demand for psychological services. The current innovation is in line with those who suggest that psychologists should place less emphasis on individual therapy and more emphasis on moving towards being educators and organisers of

services. Preliminary data on the number of AMFT groups and individuals attending the sessions presented thus far suggests that more efficient use of clinical time and reduction in numbers of patients on waiting lists can be achieved within existing resources. Further research is required to establish whether an alternative approach may optimise patient needs as non-attendance and attrition rates continue to be unacceptably high.

Anger Management Fast Track was not intended as a substitute for existing individual intervention or small group anger management, but was designed to supplement and refine the selection process for more resource and time-intensive services. Preliminary analysis affords optimism about the potential of such an service to maximise clinical time – the AMFT service was a success in screening out potential non-attenders although it may be argued that a simple waiting list initiative or patient-opt in could have achieved the same result. The programme could also have been presented by a profession other than clinical psychology. However it is hoped that the psycho-educational element of the AMFT may be developed for application to other forensic and clinical outpatient mental health referrals.

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